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THE ENCOUNTER GROUP AS AN ALTERNATIVE TO DAY HOSPITALIZATION

BY

CARROLL DIANNE GANAM

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled *THE ENCOUNTER GROUP AS AN ALTERNATIVE TO DAY HOSPITALIZATION*, submitted by Carroll Dianne Ganam in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

ABSTRACT

The purpose of this study was to investigate the comparative effectiveness of an encounter group and a day-patient hospitalization program in the alleviation of psychiatric symptomatology.

Subjects for this study were a carefully screened group of patients who were of neurotic diagnosis. Nineteen persons participated in one of two five-day residential encounter groups. Seven other persons completed a day-patient hospitalization program. Data were collected from the 26 participants, pre- post and three months following the treatment program. Additional data were obtained from relatives of subjects and from clinicians to assess participants' change. The test instruments used in this study were the MMPI, the POI, the Katz Scale of Social Adjustment, and the Brief Psychiatric Rating Scale. The data collected tested two hypotheses which were developed from theoretical considerations.

Significant change on 26 of 34 variables was obtained. On 25 of these the change was in the expected direction toward normalcy and self-actualization. This suggests that the encounter group and day-hospitalization are effective treatment vehicles.

On 30 of 34 variables measured, the three groups were not significantly different. This implies that the encounter group and day-hospitalization are of comparable therapeutic value.

Analysis of follow-up data indicated that the post treatment changes had been maintained over the three-month period.

Subsidiary findings were reported to direct attention to individual differences which may affect change.

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CHAPTER ONE

INTRODUCTION AND PROBLEM

I. Treatment of the Neurotic: Historical Perspective

The hypothesis which this study was designed to test derived from the premise that a neurotic may be responsive to treatment procedures traditionally available only to the normal or non-disturbed individual.

Earliest attitudes towards the mentally ill, as described in Coleman's (1964) overview, segregated the disturbed and attributed aberrant behavior to the devil's possession of the soul. Treatment for the symptoms was largely sadistic and involved cleansing, religious rites, etc, and invariably included the social isolation of the "possessed" person. Implicit in these methods of treatment was the corollary that disturbed behavior was not manageable by conventional behavioral interventions which were effective in producing changes in normal behavior patterns. Psychiatric understanding has moved a long way from this early bias but rudiments of its presence still exist in clinical practice.

Although agreement exists that the etiology and dynamics of all behavior (normal and disturbed) are understandable by consideration of the influence of past experience [Skinner (1957), Rogers (1961), Wolpe (1958)], treatment of the psychiatric patient does not reflect this understanding. Drug treatment, long-term psychotherapy and electrotherapy, administered in isolated institutions with locked doors, was

largely the treatment program for the disturbed individual. This resulted in removal from the community and community resources and was often a non-therapeutic experience for the patient. Gradually, however, treatment plans have moved away from the hospitalization of the disturbed, as is exemplified by the growing numbers of day care units, community treatment programs and family therapists available for the disturbed. Many publications (Zwerling, 1969) have appeared recently attesting to the effectiveness of treatment programs based in the community. Proponents relate these programs are capable of treating severely disturbed individuals out of hospital and in a manner so as to minimize the distinction between the patient and the non-disturbed person. (The question of the necessity for a neurotic-normal dichotomy will be discussed in Chapter II.)

In the past decade progress had moved more slowly in one particular area. As the encounter group movement* has gained momentum and persons who are functioning effectively in fields as diversified as business, education, medicine, and the sciences have been involved in experiences which propose to increase awareness and enhance personal function, strikingly noteworthy is the absence of a clear statement inviting the disturbed to participate in these sessions. This paper will look specifically at the question of the validity

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This term will be used interchangeably with T-Group, sensitivity group, training lab, and personal growth lab.

of exclusion of the disturbed[1] from the encounter group as a therapeutic tool, in an era of increasing knowledge and sensitivity to the requirements for good mental health.

II. Encounter Groups: Historical Perspective and Present Attitude Towards Therapeutic Use

From its accidental inception in the early 1940's, the organizational development group has metamorphosed into a variety of species, the encounter group[2] being one of these. Lewin's experience while working with a task group on problem-solving led to his conclusions that the relationships and the process of relating which occurred among the members of the task group was the main determinant in the adequacy of their solutions. He began to focus on the relationships and from this beginning, the encounter group—an experience aimed at enhancing personal growth and self-awareness of its participants—has emerged. It required, however, 15 years for this transformation to occur and during this period the T-Group developed reliable strategies for task group processing.

The first to publicly claim that the purpose of the encounter groups they would lead would be to deal with intrapsychic phenomenon (as opposed to organizational development issues) were Wechsler, Masserik and Tannenbaum, in 1962. They coined the phrase "therapy for normals" which has been

---

[1] *Defined for this paper in Chapter III, Definition of Neurotic*

[2] *Defined for this paper in Chapter III, Definition of Encounter Group*

adopted by Esalen founders and workshop leaders and the more recently developed growth centers. There was little problem with that as reputable persons in the field had no difficulty accepting this phenomenon as a promising tool for enhancing normal function. Lakin (1972) traces this historical development of encounter groups away from an original purpose of improvement of group function and personal skill to a more intrapsychic approach with its aim the personal reparative therapeutic enhancement of the individual, focussing upon the unconscious processes and aimed at emotional responsiveness. In recent years three positions on this issue have led to the present situation. On the one extreme are persons like Rogers (1970) and Perls (1969) who led encounter groups with disturbed persons. At a mid-line position would be the American Psychiatric Association (1970) which would cautiously but willingly explore this as a treatment possibility. At the other extreme is the National Training Laboratory whose spokesman, Bradford (1967), stated that there could be no blurring of the lines between therapy and training.

This points to the diversity of opinion and attitude in the field and draws attention to the need for experimental investigation directed specifically at the degree to which encounter group can be viewed as a viable alternative to the traditional treatment procedures. (The issue of the relatedness of group therapy and the encounter group will be further discussed in Chapter II.)

III. The Present Study

This study will investigate the relative effectiveness of a residential encounter group and day-patient hospitalization in the treatment of the neurotic patient.

A large body of literature now exists questioning the need for segregation of the neurotic from the larger community for treatment of his disturbance (Alexander and Selesnick, Laing, Zwerling). Trends are evident in most major therapeutic traditions to concentrate on working with the disturbed individual in his social environment and recognizing the pathology that may exist in his environmental relationships. Evidence exists suggesting hospitalization may have negative effects (Berenson and Carkhuff, 1967). Group therapies are reputed to have many advantages over individual therapy (Bovill, 1972). Combining these three trends, it appears feasible that an effective therapeutic technique would be the treatment in a group, in a non-hospital, non-clinical community setting of the disturbed patient. The experimental design will include these factors and will compare therapeutic gains[3] of a group of day-patients with patients in a residential encounter group.

This study will consider whether the encounter group is as effective as day hospitalization in the alleviation of psychiatric disturbances in groups of similarly disturbed people.

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[3] *Operationally defined for this study in Chapter III, Definitions*

IV. Relevance of the Study

Results of this study will have specific relevance for those involved in the helping professions working with disturbed individuals. Experimental evidence will indicate therapeutic directions wherein maximum patient benefit can accrue. Although there is a great deal of controversy regarding the value of encounter groups (Cooper and Maugham, 1971), evidence is available pointing out the positive results of the experience [Diedrich and Dye (1972), Cooper and Maugham 1971)]. Results of this study will have specific interest for proponents of treatment plans which would have disturbed persons treated in a non-clinical environment and would minimize the sick-well distinction. It will also provide relevant information for proponents of segregation of clinical and non-clinical populations. If the encounter group can accomplish what traditional therapy does, a case may be presented for alternative treatment programs. At the present time, when the number of persons seeking help is increasing and, in the face of the evidence pointing to the "Deterioration Effect" (Berenson and Carkhuff, 1967), referring to the equivocal findings that patients do more poorly than control subjects in some treatment conditions, the encounter group may appear as a most viable treatment alternative. This study will only investigate the encounter method with certain neurotically disturbed individuals but its effectiveness in this area may well be a preventive measure in arresting more serious disturbances in a short treatment situation.

CHAPTER TWO

THEORETICAL FOUNDATION

This chapter will approach the question of the acceptability of the encounter group as a treatment mode for select disturbed persons, firstly, by looking at the theoretical basis of the normal-neurotic distinction; secondly, by looking at the group therapy-encounter group distinction; and thirdly, by discussing relevant research surrounding these issues. A definition of the terms to be used in this study will be presented based on the literature discussed, and assumptions underlying the present study will be outlined.

I. Normal Versus Neurotic: Definition and Description

Few areas of psychology have resulted in as much difficulty in generalization of experimental results, appreciation of therapeutic technique, specification of patient group, repetition of results as the one surrounding the distinction between normal and neurotic personalities. Although, superficially, there may appear to be concensus among various schools of therapy - judging by the frequency of the terms' usage in theoretical presentations - a closer examination indicates that there are fundamental disagreements as to what really distinguishes the normal from the neurotic.

Coleman (1964) points out four approaches defining the neurotic, which include most writings in the area. They are -

1. "Frontal attack" definitions which lack specificity and scientific grounding but point up various dimensions of "mental health". He cites the example of the World Health Organization. Health is a state of complete physical, mental and social well-being, and not merely the absence of disease.

2. Multiple criteria approach. This is a technique of listing various personality traits considered essential to mental health. Different investigators (Cattell, Maslow, Eysenck), emphasize different traits and the entire structure lacks an adequate scientific base.

3. Theoretical systems approach. This is based on different views of man's nature and function, e g, emphasis on instinctual drives, the existential approach, etc. This approach suffers also from a lack of scientific validation.

4. Research approach. This is an attempt to increase our fund of scientific information. Man is investigated from a biological, psychological and sociological point of view. This is the best approach, Coleman states, but not enough information is available here to provide an adequate distinction between mental health and disorder and we must depend upon pragmatic considerations.

Resting on this justification for less than adequate rigor, generally, it is now almost implicit in most schools of clinical opinion that neurosis is a condition of dynamic maladjustment arising from a personal history of traumatic experiences and faulty attempts at adjustment, aided perhaps by some constitutional weaknesses. The specific effects of the

experiences in the personal history may vary but certain stages occur generally. These are -

1. Initially one proposes an instinct or a general motivational process which is somehow blocked.

2. Energy is used to deal with this blockage (defend against it) resulting in conflict and using up the energy making it unavailable for culturally adaptive responses.

3. Resulting behavior becomes neurotic - a label signifying the repression of awareness of the dynamic conflict and impoverished personal development.

The psychoanalytic school adopts this notion substituting words such as, libido, frustration, fixation, and conflict for those used above. Gestalt therapy operates basically within the same framework but uses an understanding of the anxiety related to incomplete gestalts and resultant psychological impasses (Perls, 1969). Rogerian therapy (Rogers, 1947) would attempt to free the growth capacities of the individual to allow him to acquire more mature ways of relating. Even animal experiments, such as those by Mowrer (1950) and Masserman (1943), explain their results with concepts supporting a conflict-adjustive process.

It is thus apparent that some concensus around this topic exists within the major psychological schools, but because the similarities are only in regards to the hypothetical constructs involved, it is possible - and in this case it is true - that very great differences emerge between the theories in the actual specification and delineation of neurotic

behavior and even further disparity occurs in distinguishing neurotic from normal behavior.

Cattell (1961) dealt with this particular issue using Coleman's second approach, as outlined above. Using a statistical approach to obtain an empirical multivariate analysis of neuroticism itself, and to understand its relationship to normalcy, neuroticism in his framework became defined in terms of a patient's scores on factors on the Cattellian tests. The emphasis here was on statistical results of test responses as contrasted to clinical diagnoses and unsystematic ratings. This method further implied that neurotic and normal phenomenon fell on a continuum and one could be understood as a continuation of the other. As with all continuums there is an intermediate zone wherein normal merges into neurotic and vice versa, and for scores in this zone the distinction of the groups becomes ambiguous. However, persons who fall in this zone may, in fact, be the ones to whom most attention should be directed in an effort to recognize and prevent serious disruption of personal behavior by dealing with neurotic symptoms as they appear in this grey zone category.

Eysenck (1965) attempted to use some scientific rigor in approaching the problem of identifying normals and neurotics. He defined neurotic behavior as learned "maladaptive" behavior. He states that, "Individuals who adopt neurotic behavior patterns fail to achieve what they are trying to do and succeed in doing what, in fact, is highly disadvantageous

to them" (p 3). It is apparent that a great deal of judgment operates here in the clinician's evaluation of what is advantageous to the patient and thus it is a subjective decision and subject to the criticisms of this form of judgment. In this framework neuroticism is disadvantageous behavior, normalcy is advantageous behavior and neither is reliably distinguishable from the other.

Looking at this procedure of defining one of these states as the opposite of the other, Freedman (1966) points to the fact that neurotic behavior is now looked upon as a disease and not a sin, but states that there is danger then in deciding that freedom from disease is normalcy and thus mental health. He points to the trend of utilizing mental health to perpetuate middle class values. This position is arrived at by equating the statistical average with adjustment. In his article he points to the inadequacy of the classification of psychiatric disorders by the American Psychiatric Association and questions the concept of differentiating normal and neurotic behavior on the basis of the presence or absence of symptoms. In a similar vein, Bieber (1966), questions what is meant by mental health. Pulling together the conceptualization of neurotics, as outlined by persons such as Freud, Spitz, Rado, Dunbar, and others, he described a profile of a mentally "healthy" individual -

> "An individual free from psychogenic symptoms. . . when exposed to reality threat he reacts appropriately, his potential for effective functioning will have been adequately and appropriately stimulated to permit its fullest development, and he will have an unimpeded capacity for its expression. He will

> have the capacity to marry a loved one with whom he sustains a consistent affectionate, sexually orgastic and companionate relationship. He will be a loving, constructive parent. Finally, he will be an individual who relates to his fellows in a consistently warm, meaningful, cooperative and assertive way. . .This profile of the mentally "healthy" individual fits no one whom I know." (p 27)

It is clear from the above that in the area of definition of neuroses there is much confusion and disparity among theorists. Close examination reveals respective bases for diagnoses of neuroses, and theoretical rationale for a normal-neurotic distinction is tenuous and ineffective in enhancing understanding of human behavior. This discussion is the basis for the suggestion this paper supports and proposes, i e, that the neurotic-normal distinction is invalid and a dichotomized view of human behavior is misguided.

R D Laing (1961 and 1964) expresses this opinion most clearly when he proposes that behavior, sick or well, is a function of the interpersonal relationships or social nexus within which a person operates. Sick and well behaviors are adopted as role complements and, as such, the subject labelled "well" is equally as sick as the subject labelled "ill", and vice versa. In this sense pathology is a misnomer or must be extended to include those who are not diagnosed as ill. The normal-neurotic distinction in this framework is then invalid.

Further expression of this approach is exemplified by Putney and Putney in the title of their book (1964), 'Normal Neurosis'. The authors argue here that we all have normal-neurotic tendencies and neurotic traits due to deprivation of

self needs. They discuss behavior of all persons in these terms and require no special conceptualization for understanding the clinical neurotic nor for outlining steps for the healthy growth of the neurotic which are different from moves towards health for the normal. Not having a neurosis then is not being normal and the theoretical issues then become hopelessly confused.

It is apparent from this discussion that some basis exists for questioning the theoretical dichotomy of normal-neurotic and the subsequent specialized treatment of the individuals dependent upon their classification in this framework. This paper does not suppose that there are no persons requiring help. Rather, it questions that, on the basis of their seeking help, they be categorized and selected for specialized treatment, and, by that process, denied community resources - particularly an encounter group experience - as a possible vehicle to aid in their trek to health and a fuller life. It proposes, alternately, that all persons may be viewed in the same conceptual framework and thus treated similarly.

II. Encounter Group Versus Group Psychotherapy

To look at the relationships that exist between these two phenomena, the most efficient procedure may be to look at them in terms of their definitions and objectives. In so doing it is important to take into account the changes these definitions and objectives have undergone in their historical evolution.

There is some disagreement over who was, in fact, the "father" of group psychotherapy. Slavson (1959) ruled out all practices prior to 1930 and the early years of that decade in his discussion of the topic. Gazda (1968), however, includes Pratt's early work in 1932 wherein the class method was used to treat tubercular patients in hygienic classes. Pratt later become aware of the psychotherapeutic value of this procedure but continued to use the class method, focussing on a topic to stimulate group interaction. Lazell, in 1921, also used didactic lectures to treat hospitalized schizophrenics in groups. Marsh, a minister, used a similar technique to involve patients with each other and to develop a therapeutic team. At this time the group was, in fact, a class whose primary objective was the mastering of some content and whose psychotherapeutic value was secondary. Moreno, in 1931, coined the phrase "group therapy" and, in 1932, "group psychotherapy". He is noted as being the single most influential person in the field, founding many journals in the area and forming the first society of group psychotherapy (American Society of Group Psychotherapy and Psychodrama). Moreno was the first to define the objectives of the group experience in psychotherapeutic terms.

Schilder and Wenden were psychiatrists who, in the late 30's, pioneered the application of psychoanalytic procedures to psychotic, hospitalized, adult patients. Slavson also emerged at this time developing activity therapy. The following decades saw a clearer expression of these early

attitudes and a refinement of the basic aim of psychotherapeutic growth for clinically disturbed individuals by a competent clinician. It was not until the last ten years that this posed a problem, but with the emergence of new forms of group experiences, confusion arose as to specific forms and populations to involve. In this context, Eric Berne (1966) perhaps makes the clearest distinction between group therapy and other forms of group interaction. In his book he defines the purpose of group therapy as the alleviation of psychiatric symptoms in psychiatrically disturbed persons. He emphasizes the clinical considerations involved and is concerned with uncovering psychopathology and determining its historic origins. He does not include in this category any of the "encounter group movement" and states that they are so dissimilar as not to be discussed together.

Few, other than strict analysts, would see the distinction so clearly. Recent publications looking at innovations to traditional group therapy include many theories that are connected to and, in fact, are the cornerstone of the new group movement, i e, gestalt therapy, here-and-now-techniques, communications skills, etc. The following authors may have been addressing themselves to the question of exclusion of the psychotic from encounter groups. They have not clearly categorized the patient groups to which they refer. This study is concerned only with neurotic patients' responses to the encounter group. Hence, it is possible that liberties are being taken with authors' opinions. It is anticipated,

that this research will give some further specification of populations appropriate to the encounter group experience.

In describing the new group therapies, Gazda, writing in 1968, looked at the most recent forms of group therapy and selected for the book he edited, articles by authors with professional stature in the field and whose theories held promise of permanence. He included articles by Corsini, Gibb, Mowrer, and Satir, persons associated as much, if not more, with the encounter group movement as with clinical therapies. The book is particularly relevant to this study as it discusses the most recent innovations in group therapy, yet quotes as authors work by persons deeply involved in the encounter movement. This is exemplified in publications by Corsini (1957, 1965) who describes "Immediate Therapy in Groups". His technique he defines as a confrontation experience arranged by a therapist. It leads to distress for the patient, conversion type phenomenon and culminates in a new understanding of self and the world and leads to improved emotional tone and behavior. He discusses in these articles therapy for clinical populations but it will become apparent in later discussion of encounter group experiences that there is a large degree of similarity in process and objectives between the two experiences.

Mowrer, in a similar vein, proponent of the new "Integrity Therapy" defines group therapy as the process whereby two or more persons become deeply and mutually acquainted. He does not distinguish between the process and

outcomes of groups of patients and non-patients and advocates against a categorical system. Mowrer indicates that a therapeutic process occurs between persons related specifically to acceptance of individual responsibility for one's life situation.

Likewise, Gibbs and Gibbs (1968), who have worked largely with non-clinical populations, postulate the TORI processes which they work towards in both therapy and non-therapy groups. These represent movement towards trust, openness, realization, and interdependence. They state that all these processes are necessary to all normal life in human organisms. They refer to their process of work toward these goals as "Emergence Therapy". They state that, as healthy social groups occur in families, work groups, etc, special therapy becomes less and less necessary in our culture. Their data, after a decade of research with therapy, sensitivity and natural groups, suggested a theory of growth based on the assumption that there are modal concerns for each individual in a group. They indicate that -

> "These concerns are present in all groups and all persons, regardless of leadership, task, structure, or social context. These concerns become life issues. Growth is a continual process of confrontation and partial resolution of these issues. Optimal growth occurs as a concurrent and interdependent development of four factors....climate, data flow, goal formation, and control." (Gibb, p 115).

The authors (Gibb and Gibb), with experience both with clinical and non-clinical populations, are perhaps most able to comment on the particular issues related to this

paper. In addressing themselves to the possibility of their emergence therapy (which they use largely with non-clinical groups) being used with clinical groups, they state -

> "Our data suggest strongly that therapy and personal growth occur during emergent group interaction under a variety of specified conditions, that the presence of a leader or therapist is not a necessary ingredient in this growth process, that certain therapist behaviors inhibit significant growth and that, under certain conditions which we are coming to understand and predict, the growth of the person is more greatly enhanced in an emergent group in which no therapist is there. . . the critical factor is the "emergent interdependence" of persons. . .treatment is best when it is aimed at enduring growth of the person rather than towards symptom removal, extirpation of an illness, exculpatory help, or even at preventive treatment."
> (Gibb, 1968, pp 122-123.)

Gendlin (1966), writing along lines similar to the above, states that, in experiential groups there is a difference from therapy groups, but adds that the differences in words and roles must not obscure the fact that in both cases there are individuals seeking one and the same thing - this being variously referred to as, freedom from alienation, openness, being in touch with what they live and feel. Gendlin, in espousing experiential groups, typifies the philosophies of the aforementioned and adds the dimension of semantics, translating group therapy goals into encounter group objectives, emphasizing the similarity in overall outcomes.

Schutz (1970) uses almost identical phrasing in talking about his encounter groups. He states that these are not therapy groups - not because he does not have patients -

but because therapy has relied on verbal, analytic, intellectual exchanges and he prefers the subjective experiential mode working towards openness, growth and personal awareness and responsibility. In his framework there is no need to distinguish between patient and non-patient for selecting treatment vehicles for each subgroup. This is similar to Gibbs (1971), who discusses dealing with psychoses that emerge in his T-Groups by using basically the same approach and attitude in all groups, i e, his TORI philosophy.

Speaking on encounter groups in 1970, Rogers stresses the humanizing elements that characterize such groups and suggests they lead to constructive exchange. He does not distinguish between patient therapy groups and the groups he runs for "normal" students.

In the most recent publication in the field directed largely at interpersonal communication, Patton and Griffin (1974) state that there are identical strategies and steps to be taken in improving interpersonal communication both in defensive, emotional persons (patients) and in normal exchanges. They advocate learning methods which can be used similarly with both groups.

Thus, it appears that group therapy, as it was originally intended, was a vehicle solely for the purpose of relief of psychiatric symptomatology. It appears, however, that this treatment has been merged with the T-Group, resulting in the new encounter group method. Leading theorists in the field have recently published in a manner which provides

the theoretical justification for the treatment of the neurotic by this mode. As outlined in Chapter I, however, this is still very much an issue of contention and disagreement and will be elaborated upon here.

Some authors have addressed themselves specifically to the question of the relatedness of encounter groups and therapy. In this context, Argyris (1970) speaks of the growing intermingling of sensitivity training and therapy. He predicts the eventual centrality of sensitivity training as a vehicle for teaching interpersonal competence in any program of positive mental health. However, he maintains that therapy will continue to be differentiated from these programs.

Awareness of the relatedness of encounter groups and therapy, as attested to by the ever-increasing numbers of professional psychotherapists forming the body of trainers and leaders in the sensitivity movement, led to the not unexpected appointment by the American Psychiatric Association of a task force to study the question. The broad range of positions held by reputable persons on this issue made the task of assessing extremely difficult. They were faced with a situation wherein several persons spoke to the similarity of both process and content between the two phenomena (Perls 1969, Lakin 1972). Wechsler, Masserik and Tannenbaum in 1962, publicly declared that they would approach the encounter group with the purpose of dealing with intrapsychic phenomena. Persons like Rogers who, in clinical practice propose self-realization and personal growth, no longer deny

that their aims are similar in encounter groups for normals. It has become apparent that, in terms of content and process, some of the newer leaders of encounter groups are using techniques and dealing with data so similar to therapy groups as to be almost indistinguishable from them.

Opposition to this position, i e, that there is marked similarity between the two processes, varied in intensity. Bradford (1967), as executive head of NTL, made the position of this organization (typically espoused as the model of responsibly led, educative, non-therapy groups) very clear. His publication stressed the non-therapeutic intent and focus of NTL workshops. Golembiewsky and Blumberg (1970) adopted essentially the same point of view. They concluded that all reputable sensitivity groups caution against its use as a therapy substitute.

Finally, midway between the two positions espoused above was that taken by practitioners represented by Clark (1970) who state that the therapy-versus-training issue can be resolved by clear statements of the goals of the groups. Neither is inherently superior nor more vital. In a similar vein, Lakin (1972) stated that he does not intend to give "blanket approval to or unequivocal censure"[1] to the trend of training with a therapy-like purpose.

In the face then of these widely disparate opinions of the relevance of the encounter group to psychiatry, the

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[1] *Lakin, p 213*

APA task force, referred to earlier, obtained and published its findings in April of 1970. Its paraphrased summary statements are that encounter groups are non-therapy or educative and that all members who have a high likelihood of adverse psychological consequences should be screened at the point prior to or during the group that this propensity for psychologically disturbed behavior is manifested. The report, in its author's own words, is "tentative"[2], based on very little research (research being sorely needed to put fact where now only opinion is available). In spite of these cautionary notes the task force advises mental health professionals to gain as much information as they can about encounter groups and stresses the implications for the mental health field. They indicate that techniques have been borrowed from the growth movement for clinical therapy, and that some psychiatrists lead, participate in and refer their patients to encounter groups. This report summarizes its findings by pointing to the salient need for research to provide more information on which future psychiatric involvement for both patient and staff can be guided.

To summarize - historically, group therapy and encounter groups represented parallel although separate bodies of knowledge and practice. However, some informed persons hold that this parallelism is presently approaching almost complete unity. Questions have arisen as to the degree to

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[2] *APA Task Force, p 3*

which these two experiences can mold and be used interchangeably. On the one hand there are those who, like Rogers and Perls, would make no distinction between therapy for normals and therapy for the clinically disturbed, hence, would readily use the encounter group as a clinical treatment vehicle. Holding a more median position would be the APA with its caution but willingness to explore the possibilities of mingling the two. At the other extreme is the NTL which would have no blurring of the lines between therapy and training. All of these attitudes are based upon theories acceptable to these individuals, their personal conviction and experience. Experimental support is not available to test the theories. It appears crucial that research be directed specifically at the question of the degree to which therapeutic gains can be obtained by use of the encounter group technique with clinically disturbed individuals.

Relevant Research

It is obvious that in this field there is a dearth of specific information evaluating the encounter group as a treatment vehicle for disturbed persons. To this author's knowledge there is only one study closely related to the issue at hand. It is a study by Vernallis, et al (1970) wherein is used a format which closely resembles T-Group techniques. He met for a marathon sixteen weekends of therapy with psychiatric patients who received no other in-hospital treatment. His experimental subjects showed significantly more psychological

gain and better adjustment than did a control group of in-hospital patients. Somewhat related is a study by Bovil (1972) which evaluated group psychotherapy for neurotics against regular in-hospital treatment. Her experimental group had less than one-seventh the re-admissions of the control group (no group experience) in a follow-up period.

Of further interest - not for the statistical information they yield but to exemplify the growing interest of professionals in the relationship of the human relations movement to psychiatry - are articles by Gottschalk and Pattison (1972) who present an overview of the psychiatric perspectives in T-Groups. They state the group movement merits attention because it contains relevant information on human behavior and interpersonal function and has proven to be effective in promoting health. They list seven distinct areas wherein psychiatry can learn from the encounter movement, indicating increased awareness of the parallel between the two. Similarly, Grant (1972), in addressing the Australian Institute of Human Relations, concludes that the areas of psychiatry and the encounter movement have much to offer each other.

In addition to the statements above are opinion statements contradicting the advocacy of increasing mutuality of purpose and process between these two phenomenon. Kuehn and Corneilla (1972) feel that psychotics, characterologic neurotics, hysterics, and individuals in crises should be excluded from encounter group experiences. They have no

research to support their opinions, but their statement is reflective of the concern and legitimate wariness of professionals who feel an ethical responsibility for those involved. Berger (1973) reflects this same concern, cautioning against too easy dismissal of the obligation that leaders should feel toward those who experience psychological upset in an encounter experience.

It is apparent that the state of the publications representative of attitudes in the field require a great deal of empirical research to provide factual bases for the opinions and concerns held by persons in the field. The publications, however, point also to a growing awareness of the possibilities of combining the resources of psychiatry and other professions to lead to more effective experiences for both the disturbed and the non-disturbed. The fact that three large bodies representative of the professional associations in their respective countries, i e, American Psychiatric Association, British Journal of Psychiatry, which, in 1973 dedicated one issue to a study of the group phenomenon, and the Australian and New Zealand Institute of Human Relations which devoted its 1972 annual meeting to a discussion of the group movement, attests to the increasing mutual interest of psychiatry and those involved in the encounter movement in enhancing individual growth.

CHAPTER THREE

DEFINITIONS

Basic to a clear understanding of the variables involved in this study are operational definitions of the key referents used. The ambiguity surrounding the terms has been demonstrated to be intense, leaving the operational definition the most effective alternative for specification of the concepts involved. This chapter outlines the definitions and the assumptions underlying this study.

1. Neurotic

Included for study in this paper were persons who had approached a psychiatrist for personal help. Five psychiatrists referred persons to this study. All had exposure to clinical and non-clinical group experiences in their work histories; each was asked to select criteria they would use to screen participants from an encounter group. From the five lists (see Appendix A), a comprehensive set of criteria was tabulated. This was derived in such a manner as to ensure minimum risk for the patient participants. It included maximum exclusion of pathology as specified by the psychiatrists. Where there was overlap by different psychiatrists, the criterion which allowed for inclusion of the least pathology was retained. The final compilation of criteria was as follows.

1. They have no history of psychotic episodes.

2. They are not judged to be bordering on a psychosis.

3. They are judged to have potential for emotional growth from such an experience.

4. Most neurotic personality disorders be included. This allows for patients with psychosomatic disorders, reactive depressions, mild hysterics, abnormal anxiety states, poor self-concepts.

5. They be of at least average intelligence.

6. They be within the age range of 20 to 45 years.

7. Neurotic patients to be excluded from this group are:

A. those with poor controls, impulsive acting-out histories,

B. psychopathic personality disorders,

C. hostile patients whose hostility is related to homosexuality,

D. paranoids,

E. those whose life pattern has shown inadequate reality testing, i e, have seemed unable to learn from experience or whose responses are habitually not appropriate to situations,

F. severe obsessionals or ruminators,

G. those whose affect seems supercilious,

H. those with no sense of humor.

Thus, for this study, a neurotic is defined as an individual who approached a psychiatrist for help and, on the basis of that psychiatrist's clinical judgment, met the seven criteria listed above.

2. Encounter Group

In order to define operationally this term, it being unfeasible to make this both a process and an outcome study, the two trainers and two co-trainers were asked to submit descriptions of their philosophies, techniques and objectives for encounter groups as they lead them. (See Appendix B for these detailed accounts in their original forms.) To ascertain that the therapists did in fact function in a manner consistent with their descriptions, video tapes of ten sessions of each group were made at random periods throughout the laboratory. Four graduate students in Educational Psychology, who had successfully completed the advanced course in groups (Ed Psych 518), were given the complete descriptions as the therapists had given them. The students did not know who was the author of the description. Some of the students had previous limited contact with some of the therapists, some had none. It was thought this would not be a critical factor as the therapists would function fairly consistently over time and the descriptions should remain accurate for each individual regardless of the time his behavior was sampled. The students were, in fact, able to match the video-taped style for the leaders to their self-descriptions fairly accurately (see Chapter V and Table XVI for statistical data). On this information it appears legitimate to describe the encounter groups on the basis of the leaders' descriptions of their own styles.

Group A, then, will be operationally defined as a

function of the styles of leaders A and B (see Appendix B). Leaders here would facilitate participants' seeing themselves as others see them, learn fundamental communications skills, accept personal responsibility for their actions, and increase self-awareness. In this framework some structured exercises and short theory inputs would be expected. The emphasis is on immediate awarenesses and gaining of an understanding of personal feelings and actions. This group will thus focus on personal growth issues, centering on awareness of present feeling, with some attention given to learning communications skills to enhance mutual understanding.

Group B will be defined as a function of the leadership styles of therapists C and D (see Appendix B). Here the leaders would create an atmosphere of personal exploration, focussing on the individual's accepting responsibility for his life situation and facilitating his recognizing the ways in which he influences his own self-perceptions. Here, the leadership styles serve as complements to each other with one working towards utilizing group resources and the other focussing on individual experiences. Some gestalt techniques, self-disclosing activity and a focussing on the awarenesses in the "here and now" would be part of this form of encounter group.

Thus, from this point on, the term 'encounter group' will refer to the two descriptions outlined above. Except for a discussion of the experimental results, no distinction

will be made between these two descriptions as no major dissimilarities (with the exception of the theoretical inputs) are apparent between the two. This issue will be further expanded upon in Chapter IV where the encounter laboratory is more extensively described as it was a part of this study.

3. Therapeutic Gains

In this paper it is important to recognize that a comparison is being made between outcomes of the encounter group experience and day-hospitalization of neurotics. With the particular population concerned here, and to make a case for the encounter group as an alternative to clinical treatment, it is necessary to evaluate the results largely in terms of clinical change rather than in terms of the particular objectives of encounter groups. Traditional treatment will look to a reduction of psychopathology and reduction of clinical manifestations of disturbance. Operating from this basis, results for persons involved in the encounter group will be evaluated in terms of clinical improvement. This will be done by measuring movement away from pathology towards the normal on various clinical dimensions. The specific instruments to be used will be described in Chapter IV. Thus, the operational definition of therapeutic gain or improvement, in this study, will be a measure of clinical change as obtained on various rating devices.

Assumptions Underlying this Study

The theoretical bases for these assumptions are found in the preceding discussion. The following is a condensation and integration of these ideas and will be presented in an abbreviated form because of this.

1. *That the neurotic is not essentially different from the normal and that the treatment of the neurotic is not necessarily the most adequate solution.*

Support for this assumption is derived from the writings of R D Laing (1961 and 1964) who proposes that behavior, sick or well, is a function of the interpersonal relationships or social nexus within which a person operates; the normal-neurotic distinction is then invalid. Ruitenbeek (1972), espousing this view also, rejects completely the application of the psychiatric structure and theories to contemporary mental illness.

2. *That hospitalization is not a necessary part of the treatment of the neurotic and that there are other alternatives available.*

This is supported by the ever increasing numbers of day hospitals and community treatment programs in the mental health field. This suggests growing concern that hospitalization may only serve to accentuate and perpetuate dependencies which may be handled much more effectively by out-of-hospital treatment. Zwerling (1970) makes a case for handling even the most acute psychotic in a day-patient facility.

Growing from these attitudes is the present study

which will attempt to test their validity. As cited earlier the specific purpose of this study will be to compare the relative effectiveness of traditional day-hospital treatment plans with the encounter group method in obtaining therapeutic gain with particular psychiatric patients.

CHAPTER FOUR

METHODOLOGY

Design of the Study

A formal statement of the hypotheses of the study is presented in this chapter. A description of the instruments used and the rationale for their selection, and a description of the subject sample is given. Trainers are described, clinical raters and development of inter-judge rating reliability is outlined. The experimental and control conditions are described, and the procedure for establishing these conditions is outlined. Finally, the procedure used for collecting and analyzing results is presented.

I. Hypotheses Tested

Hypothesis 1. That neurotic patients in an encounter group experience obtain therapeutic gain from the experience as depicted by movement toward health on clinical measures, specifically, the MMPI, POI, Katz Adjustment Scale, and the Overall and Gorham Psychiatric Rating Scale.

Hypothesis 2. That patients in an encounter group obtain at least as much therapeutic gain as a control group of patients in a day-care hospital treatment program, as depicted by comparison of their scores on the above clinical measures.

II. Instruments Used in the Study

To meet Bodnar's (1970) recommendations for research in group therapy dependent variables were assessed from three data sources. These were -

a) Behavior change that is directly observable. Information related to drug usage, etc was obtained from each patient.

b) Inferred behavior change. Objective psychological measurements, rather than projective measures, were suggested here and were completed by the subject.

c) Perception of change. Bodnar suggested rating scales and the use of expert judges and close family members to adequately assess the subject. This was included in consideration of the selection of instruments.

1. The MMPI - The Minnesota Multiphasic Personality Inventory, developed by Hathaway and Meehl, consists of 566 items which compile ten clinical scales and three validity scales. Extensive work has been done on this test and reliabilities and predictive validities are well documented and are generally high. It is probably the most widely used objective personality questionnaire available and yields measures of personal adjustment on the ten clinical symptom scales (Lanyon and Goodstein, 1971).

2. The POI - The Personal Orientation Inventory was developed by E Shostrom in 1963. It consists of 150 two-choice comparative value judgment items. It purports to measure positive

mental health as reflected in concepts of self-actualization. There are extensive data assessing the adequacy of the POI in differentiating clinical populations on the dimensions of self-actualization [Shostrom (1965), Fox (1965), Fox, Knapp and Michael (1968)]. Comparison of MMPI and POI scores with out-patients yielded negative correlations of significant magnitude to support the contention that POI scores tap areas of "emotional morale" or psychological well-being (Shostrom and Knapp, 1966). Additionally, the POI has been used extensively to measure effects of group experience. Results here are equivocal as some authors (LeMay and Damm, 1970) report no change on the POI after a group experience. Guinan and Foulds (1970), and Flandis (1969), however, found significant results in comparing pre- and post sensitivity training scores on 7 and 8 of the 12 POI scales and in a positive direction for the remaining 5 and 4. For these two reasons the POI was selected for this study, i e, it has been demonstrated to effectively compare with MMPI results in clinical populations and it has been shown to be an effective measure of change in sensitivity group experiences. Additionally, with the exception of three subscales, reliability coefficients range generally high (from .71 to .85) in a study of this question by Klavetter and Mogar (1967).

3. Katz Adjustment Scale - This is a test devised by Martin M Katz and Samuel B Lyerly using the relative of the patient to assess the patient in three areas: (a) symptoms and social behavior, (b) performance of socially-expected activities,

and (c) level of free-time activities. Also, the relative rates the degree to which he is satisfied with the patient's behavior in areas (b) and (c). Items for each scale were obtained by factor analysis of an item pool. All items within the cluster had internal consistencies of .63 to .87 over two samples thus giving a satisfactory test of their stability. The 127 items in the first area of patient function (symptom and social behavior) were factor analyzed to yield five clusters. Only one of these was used for data in this study. This was the factor measuring General Psychopathology and included 24 items. The four subscales were dropped because it was thought that this would not sacrifice information on this study as -

1. The test authors report a correlation of .79 between clinician's and relative's ratings on patient symptomatology.

2. This study includes clinician's ratings.

3. The number of scores for each patient totals 34 which would appear to give an adequate assessment of the patient as well as results in a large number of variables to be considered in statistical analysis.

The test was chosen particularly as it is one of the few tests with scales designed for application to the problem of describing and classifying patients in accordance with their behavior prior to entrance to hospital and in the community follow-up evaluation. It was also designed to evaluate comparisons of treatment conditions. Evidence of its reliability and validity from researchers other than the

original developers of the test is not available. The complete test is reproduced in Appendix C.

4. Brief Psychiatric Rating Scale - This test was developed in 1962 by John Overall and Donald Gorham to provide a rapid assessment technique particularly suited to the evaluation of patient change. Sixteen symptom constructs, obtained by factor analysis of a pool of items, are included for rating on a 7 point ordered category rating scale. The procedure involves a 15-minute interview of the patient by two clinical raters whose inter-rating reliability has been established to be satisfactory (described for this study under clinical raters) who then rate the patient independently on the sixteen symptoms. Scores are averaged over each scale to provide one measure for each patient. The sixteen scale scores are then added to yield a General Pathology scale score. Authors of the scale recommend this technique of obtaining a single scale score to evaluate patient change during treatments as their research indicates that, in spite of the search for specific treatment differences, differences between pre- and post-treatment pathology is best represented by a single dimension spanning the multi-variates (Overall and Gorham, 1960). Investigation of the reliability of this test has taken the form of inter-rater reliability. Reliabilities are reported of .56 to .90 with the majority falling at +.80. The above four tests result in a total of 34 scores for each subject.

III. Subjects

A total of 26 persons were involved in the study. All had approached a psychiatrist for personal therapy. They were then referred to the study if the psychiatrist determined to his satisfaction that they met the seven criteria outlined in Chapter III. Nineteen patients were involved in one of two encounter groups (experimental conditions) and seven patients, who served as controls, received treatment at the day-patient facility of the Royal Alexandra Hospital in Edmonton. No attempt was made to control for factors such as age, education, income, previous therapy experiences, although demographic information was obtained for each to add specificity in the results section. The psychiatrists were given the set of criteria to select patients. A total of 19 persons were referred to the groups. Random assignment was not possible as the first 19 persons who qualified for the study and presented themselves to the psychiatrist's office were referred to the encounter group conditions. In order to allow for the planning and arranging of time for the groups, it was necessary to use the first 19 persons rather than wait for a subject pool of 26 and then randomly assign to the three conditions. After the encounter groups had sufficient subjects, the next seven persons admitted to the day-patient unit and who satisfied the criteria, became the control condition.

The 19 participants in the experimental conditions received basic information regarding the encounter group and

were told only that it was designed as a therapeutic experience and that due to the research nature of the situation data would be collected (see Appendix D for the complete letter). The 19 subjects were assigned to two groups of ten and nine persons, respectively. There were six males in the sample and they were assigned three to each group. One married couple was split and one assigned to each group and, for one subject, the psychiatrist preferred that she not be in his group because of his extensive work history with her. Excluding these exceptions, subjects were randomly assigned to the two groups.

The remaining seven subjects in the control condition were patients who met the seven criteria and who were admitted to the day-patient facility of the Royal Alexandra Hospital. As patients were admitted they were evaluated against the criteria and, if they met the requirements and were willing, they became part of the control group.

IV. Trainers

Trainers for Group A were a psychiatrist and a psychologist. The psychiatrist had extensive experience in group work with normals and clinical populations. The psychologist had worked more extensively with T-Group and organizational development group work. Self-descriptions of their individual styles are included in Appendix B.

Trainers for Group B were a psychiatrist and a psychologist. Both had extensive group experience in both

clinical and non-clinical group work. Self-descriptions of their styles are included in Appendix B.

An assumption that operated here was that extensive experience in group work would probably result in an eclectic style which would allow for generalization of results from this encounter group to other encounter group experiences. Both sets of trainers were selected because of their own extensive exposure to encounter groups. Psychiatrists were specifically selected on the basis of their skills and also to provide maximum protection for the patients, and to ensure that psychological crises could be met with maximum medical and therapeutic resources.

V. Clinical Raters and Development of Inter-Judge Rating Reliability

Seven employees of the psychiatric unit of the Royal Alexandra Hospital worked as teams in the rating of the patients on the Brief Psychiatric Rating Scale. They included a psychologist, a social worker, an occupational therapist, and four nurses. The group met on four occasions to practice and become skilled in using the instrument. The raters met with the researcher on a once-per-week basis for approximately two and one-half hours to become familiar with the rating scale and to obtain a satisfactory inter-judge rating reliability. A total of eight patients (not subjects in the study) were interviewed in these practice situations. The procedure had two of the seven interviewers meet with an

out-patient at the Royal Alexandra Hospital. The interview followed the procedure described by Overall and Gorham (see Appendix E) and took approximately twenty minutes to complete. The other raters and the researcher observed the interview through a one-way screen. Upon completion the seven clinicians rated the patient on the scale. The raters then discussed their findings and rationale for their scores. This involved eight patients; data was recorded on the last six, after it seemed that there was agreement and concensus in understanding the behavior and symptoms assessed by the questionnaire. Inter-judge rating reliability was assessed from the data and is recorded in Table XV.

VI. Experimental and Control Conditions

Groups A and B participated in residential encounter groups of five days' duration, held at the Holy Redeemer College in March of 1973. The groups were held at the same time in the same building. Each group met separately for two or three sessions per day. Combined group sessions were held four times throughout the five days and generally revolved around a theoretical input and/or theoretical handouts. Both groups attended these sessions. An attempt was made to keep the format as close to the traditional encounter group or personal growth lab as possible. Groups A and B had two trainers (a psychiatrist and a psychologist) who worked together in each session. All sessions were tape recorded and five sessions per group were video-taped.

Group C (the control condition) participated in a regular hospital stay as out-patient admissions at the Royal Alexandra Hospital. No attempt was made to control for duration of treatment, medication, etc, as it was thought that the best comparison of the encounter group to traditional treatment would be to take a treatment program as it exists and to allow the patient to enter the program and complete it in its entirety. Generally, the hospital program may be described as espousing a therapeutic milieu philosophy. Patients admitted to the program enter a typical treatment facility. They are involved in occupational therapy, group therapy, have individual interviews with nurses and doctors, may or may not take medication, participate in patient government of their ward, etc. Maximum length of stay on the unit is three months and, in this sample, treatment programs ranged from three weeks to ten weeks, the average being six and one-half weeks.

VII. Data Collection: Method and Stages

Consistent with Bodnar's recommendations for research, dependent variables were assessed by three methods -

(a) Observable behavior. Length of stay for out-patients, re-admission rates, use of medication following treatment, psychotherapy visits, follow-up period, etc, were recorded.

(b) Inferred behavior change. Subjects completed the MMPI and the POI in a large room the evening preceding the group experience and in the afternoon following the final group

session, and three months following the group experience for persons in conditions A and B. Subjects in the control condition completed the MMPI and the POI immediately upon admission, at discharge, and three months following their day-patient hospitalization.

(c) Perception of change by expert raters and others. The Katz Adjustment Scale was completed by a person close to the subject the evening prior to the encounter group, one week following the end of the encounter group, and three months following the end of the encounter group for subjects in conditions A and B. For subjects in condition C this was done on admission, at discharge, and three months following discharge from day-patient hospitalization. The Brief Psychiatric Rating Scale was completed by two of the seven raters the evening prior to the encounter group, the afternoon following the last session, and three months following the last session for conditions A and B, and for group C, on admission, at discharge, and three months following discharge from day-patient hospitalization.

Obtaining Data

Of the original 19 participants in the encounter group conditions of the study, complete pre-, post data are available on 16 persons; complete pre- post and follow-up data are available for 12 persons; and complete pre- post and partial follow-up data are available on an additional four persons.

Three of the original 19 participants did not complete the post treatment data. One of these took the questionnaires home rather than complete them at the lab setting and when contacted several days later said she would return them but didn't. She called at follow-up time to say she was leaving Edmonton, could not attend the follow-up session and would not have time to complete the questionnaires. Her psychiatrist indicated that she feels positive about the experience but is clinically unchanged. A second female's relative could not rate her at the week following the group as she said the patient had not spent the week at her home. This was usual behavior for the patient and she could not be reached for follow-up. The husband of a third female left her during the group and did not complete the post treatment data on his wife. The patient subsequently required psychiatric help and hospitalization but her psychiatrist indicated this was related to her husband's leaving and not to the group, which the patient considered as a positive experience for her. The patient moved to Eastern Canada and has not been followed up. The remaining 16 patients had complete pre- and post data. However, four had only partial follow-up data. Two of these were unable to obtain relative's rating, one misplaced her questionnaires, then required open heart surgery, one invalidated a questionnaire by omitting a set of questions.

Of the seven patients who served in the control group, complete pre- post and follow-up data are available on five.

Complete pre- and post data are available on all seven patients. For the two who did not provide follow-up ratings, one moved to Calgary and was unable to arrange the clinical interview. One was hostile to the hospital and refused to do the follow-up. (It was difficult to obtain a large sample for the control group due to several months' limited admission at the Royal Alexandra Hospital because of an impending strike, followed by a strike.)

Graphically, the above information may be presented simply, as follows (Table I).

TABLE I
PARTICIPANTS AND STAGES OF DATA COLLECTION

	Number of Participants			
Condition	*Pre data*	*Post data*	*Complete followup*	*Partial followup*
Encounter A	9	8	5	3
Encounter B	10	8	7	1
Control C	7	7	5	0

VIII. Data Analysis

The procedure followed in hypothesis testing is outlined below.

Hypothesis 1. All tests and questionnaires were scored to yield scale scores. For the MMPI this resulted in three validity scale scores and ten clinical symptom scores. For the POI this resulted in fourteen scale scores measuring

aspects of mental health. For the Katz Adjustment Scale this resulted in three scores measuring patient behavior, two measuring relative's expectations of patient, and one measuring discrepancy of patient behavior and relative expectation. For the Brief Psychiatric Rating Scale this resulted in one score measuring general pathology.

A two-way analysis of variance was applied to the data to assess changes from pre- post and follow-up.

Hypothesis 2. The scored data as in Hypothesis 1 were used. A two-way analysis of variance was applied to the data to assess the extent of interaction among the three groups.

Initially, data were analyzed in this manner for pre- post differences due to the small sample size available for pre- post and follow-up differences. Secondly data were analyzed for the pre- post, follow-up differences.

The two encounter groups were compared for significance of differences between them.

CHAPTER FIVE

RESULTS

This chapter will include the results of hypothesis testing which will be presented first. A variety of other statistical analyses were applied to various stages of the data and much work preceded the testing. To determine that the data met the assumptions required for analysis, statistical investigations were undertaken prior to hypothesis testing. This information is presented following the results of hypothesis testing as is the relevant statistical investigation of ancillary questions.

Results of Hypothesis Testing

[Note - To test the main hypotheses, the pre post data analyses were done. (Follow-up data analyses are included after hypothesis testing.)]

Hypothesis 1. Analysis of variance yielded results consistent with the expectation that patients in an encounter group would show positive therapeutic gain. On 26 of 34 variables, there was significant obtained difference between pre and post test scores ($p < .05$). (See Table II.) Results are shown on Graphs A and B and indicate that the direction of change on all but one variable was towards the normal or towards the norms expected for self-actualizing individuals. The exception was on Variable 11 (Mania-MMPI) for the two experimental groups and will be elaborated upon further in Chapter VI.

TABLE II
SUMMARY OF ANALYSIS OF VARIANCE RESULTS
PRE-POST DIFFERENCES

Variable	*Probability level*	*Support for hypothesis*
MMPI		
1. Lie	.0207	yes
2. Fake	.0027	yes
3. K	.0734	no
4. Hypochondriasis	.0514	no
5. Depression	.0001	yes
6. Hysteria	.0001	yes
7. Psychopathic deviancy	.0005	yes
8. Sexuality	.7758	no
9. Paranoia	.0057	yes
10. Psychasthenia	.0003	yes
11. Mania	.0330	yes*
12. Schizophrenia	.0005	yes
13. Social introversion	.0033	yes
POI		
14. Time incompetent	.0009	yes
15. Time competent	.0102	yes
16. Other directed	.0011	yes
17. Inner directed	.0033	yes
18. Self-actualizing value	.0008	yes
19. Existentiality	.0020	yes
20. Feeling reactivity	.0020	yes
21. Spontaneity	.0001	yes
22. Self-regard	.0006	yes
23. Self-acceptance	.0023	yes
24. Nature of man-constructive	.0251	yes
25. Synergy	.0122	yes
26. Accept aggression	.0064	yes
27. Capacity for intimate contact	.0003	yes
Brief Psychiatric Rating Scale		
28. General pathology	.0142	yes
Katz Scale for Social Adjustment		
29. General psychopathology	.0004	yes
30. Social activity	.8175	no
31. Relative's expectation	.5721	no
32. Level of free time activity	.9255	no
33. Relative's satisfaction with 32	.0682	no
34. Discrepancy of patient behavior and relative's expectation	.6626	no

**changes in unexpected direction*

Hypothesis 2. Table III provides a summary of the data assessing the comparative differences among the groups. It is predicted that the experimental groups, i e, the encounter groups, would do as well as the control group. No significant differences are expected among them. Exceptions to this are predicted to be in the direction of the experimental groups having achieved a more positive level of personal adjustment than the control group.

TABLE III
SUMMARY OF ANALYSIS OF VARIANCE RESULTS
PRE - POST DIFFERENCES AMONG GROUPS

Variable	*Probability level*	*Support for hypothesis*
MMPI		
1. Lie	.5819	yes
2. Fake	.3204	yes
3. K	.9277	yes
4. Hypochondriasis	.5133	yes
5. Depression	.2355	yes
6. Hysteria	.3789	yes
7. Psychopathic Deviancy	.1183	yes
8. Sexuality	.5025	yes
9. Paranoia	.3004	yes
10. Psychasthenia	.3484	yes
11. Mania	.0266	no
12. Schizophrenia	.3801	yes
13. Social Introversion	.5728	yes
POI		
14. Time incompetent	.6681	yes
15. Time competent	.3278	yes
16. Other directed	.1626	yes
17. Inner directed	.0625	yes
18. Self-actualizing value	.2829	yes
19. Existentiality	.2473	yes
20. Feeling reactivity	.0303	no
21. Spontaneity	.0136	no
22. Self-regard	.2770	yes
23. Self-acceptance	.7952	yes
24. Nature of man-constructive	.7952	yes
25. Synergy	.0711	yes
26. Accept aggression	.1727	yes
27. Capacity for intimate contact	.0482	no
Brief Psychiatric Rating Scale		
28. General pathology	.3491	yes
Katz Scale for Social Adjustment		
29. General psychopathology	.3772	yes
30. Social activity	.1682	yes
31. Relative's expectation for 30.	.5577	yes
32. Level of free time activity	.2337	yes
33. Relative's satisfaction with 32.	.6025	yes
34. Discrepancy of patient behavior and relative's expectation	.0988	yes

The above table summarizes the findings related to Hypothesis 2 and indicates that on 30 of 34 variables the groups were not significantly different from each other and supports the hypothesis. On the four variables where significant differences were obtained, a test for the significance of the differences among the pairs of groups was applied to determine which of the three groups was significantly different. This information is in Table IV.

TABLE IV
IDENTIFICATION OF DIFFERENCES AMONG GROUPS
WHERE SIGNIFICANT DIFFERENCES WERE OBTAINED

Variable	*Probability level<*	*Support for hypothesis*
11. Mania *(MMPI)* Group A significantly higher than Control C at post	.10	No, movement is away from the normal
Group B significantly higher than Control C at Post	.025	No, movement is away from the normal
20. Feeling reactivity *(POI)* Group A significantly closer to the Self-actualizing norm than Control C	.025	Yes
21. Spontaneity *(POI)* Group A significantly closer to Self-actualizing norm than Control C	.10	Yes
27. Capacity for intimate contact *(POI)* Not due to treatment effects Group A significantly higher than Control at pre-test	.250	-

The results indicate that the groups are not generally different from each other. On four of the variables, however, the groups were different. In two cases change was in the direction predicted by the hypothesis, in one case in the unexpected direction, and in the fourth, was due to initial sample differences. (The probabilities that these findings could occur by chance is relatively high and suggest only a possible trend for differences, rather than reliable differences among groups.)

Results of Interaction Effects

Additional information is provided by a consideration of the interaction effects of these variables. In view of the prediction that all groups would do equally well, it was hypothesized that there would be little interaction among groups and times. Results of the analysis of interaction effects for each variable are provided in Table V.

TABLE V
SUMMARY OF INTERACTION EFFECTS OF GROUP X TIME

Variable	*Probability level*	*Support expectation*
MMPI		
1. Lie	.2946	yes
2. Fake	.0447	no
3. K	.0426	no
4. Hypochondriasis	.0514	yes
5. Depression	.0450	no
6. Hysteria	.0302	no
7. Psychopathic deviancy	.1148	yes
8. Sexuality	.2318	yes
9. Paranoia	.0011	no
10. Psychasthenia	.0003	no
11. Mania	.3098	yes
12. Schizophrenia	.0008	no
13. Social introversion	.0472	no
POI		
14. Time incompetent	.2366	yes
15. Time competent	.1360	yes
16. Other directed	.0235	no
17. Inner directed	.1060	yes
18. Self-actualizing value	.5901	yes
19. Existentiality	.0438	no
20. Feeling reactivity	.0792	yes
21. Spontaneity	.0380	no
22. Self-regard	.0891	yes
23. Self-acceptance	.5980	yes
24. Nature of man-constructive	.5927	yes
25. Synergy	.7471	yes
26. Accept aggression	.0391	no
27. Capacity for intimate contact	.0263	no
Brief Psychiatric Rating Scale		
28. General pathology	.1249	yes
Katz Social Adjustment Scale		
29. General psychopathology	.8140	yes
30. Social activity	.0655	yes
31. Relative's expectation of 30	.0149	no
32. Level of free time activity	.0883	yes
33. Relative's satisfaction with 32	.5803	yes
34. Discrepancy of patient behavior and relative's expectation	.2755	yes

On 14 variables there was significant interaction. These data were subjected to analysis using the Scheffé Test to determine the source of the interaction effect. These results are presented in Table VI and indicate that, but for five exceptions, the interaction effect is due to some statistical combination of the various means and not due to the effect of a single group's differential reaction to the treatment condition. Table VII summarizes the data for those variables wherein the significant interaction was demonstrated to be related to the treatment conditions.

TABLE VI
SUMMARY OF GROUP DIFFERENTIAL REACTION TO TREATMENT WHEREIN SIGNIFICANT INTERACTION WAS OBTAINED

Variable	*Probability level*	*Effect*
2. Fake	.025	C had a significantly greater change than A or B
5. Depression	.10	C had a significantly greater change than A or B
6. Hysteria	.025	C had a significantly greater change than A
9. Paranoia	.10	C had a significantly greater change than B
12. Schizophrenia	.10	C had a significantly greater change than A or B

Integrating these results of analysis on pre- post score differences it appears that, essentially there was little interaction, i e, the treatments did not have a differential effect on the groups. Table I indicated that on 26 variables there was significant change. Table VI indicates that on five of these variables the improvement was significantly different for the groups. In all these cases the control group improved more than did the experimental groups, at least Group A and in some instances Group B as well. Table VI indicates, however, that Group A achieved a greater movement towards self-actualization than the control on two variables, but that both the experimental groups moved further from the normal on the 11th variable (Mania) after treatment as compared to movement towards the norm for the control group on this variable. Thus the groups showed significant improvement on the majority of variables with Group C showing a slightly greater degree of change than the experimental groups on five variables. These data are summarized in Table VII.

TABLE VII
SUMMARY OF PRE- POST DATA ANALYSIS RESULTS

Significant change in expected direction on 25 variables
Significant change in unexpected direction on 1 variable(Mania)
Significant difference among groups on 4 variables (Table IV)
Significant interaction due to treatment on 5 variables (Table VI)

Results of Pre- Post Follow-up Data Analysis

Further analysis of the data was undertaken to assess the degree to which the change present at post treatment assessment was maintained in a three-month follow-up period. The sample size for this analysis is smaller than for investigation of pre- post treatment data, as was explained in Chapter IV. Table VIII outlines a summary of all the findings of a two-way analysis of variance for these data.

TABLE VIII
PRE- POST FOLLOW-UP DIFFERENCES
SUMMARY OF ANALYSIS OF VARIANCE

Variable	*Among groups*	*Over-time*	*Inter-action*
MMPI			
1. Lie	ns	sig	ns
2. Fake	ns	sig	ns*
3. K	ns	sig*	ns*
4. Hypochondriasis	ns	sig	ns
5. Depression	ns	sig	sig
6. Hysteria	ns	sig	ns*
7. Psychopathic deviancy	ns	sig	ns
8. Sexuality	ns	ns	ns
9. Paranoia	ns	sig	sig
10. Psychasthenia	ns	sig	sig
11. Mania	ns*	ns*	ns
12. Schizophrenia	ns	sig	sig
13. Social introversion	ns	sig	sig
POI			
14. Time incompetent	ns	sig	sig*
15. Time competent	ns	sig	sig*
16. Other directed	ns	sig	sig
17. Inner directed	ns	sig	sig*
18. Self-actualizing value	ns	sig	ns
19. Existentiality	ns	sig	sig
20. Feeling reactivity	ns*	sig	ns
21. Spontaneity	ns*	sig	sig
22. Self-regard	ns	sig	sig*
23. Self-acceptance	ns	sig	ns
24. Nature of man-constructive	ns	sig	ns
25. Synergy	ns	sig	ns
26. Accept aggression	ns	sig	sig
27. Capacity for intimate contact	ns*	sig	ns*
Brief Psychiatric Rating Scale			
28. General pathology	ns	sig	ns
Katz Scale for Social Adjustment			
29. General psychopathology	ns	sig	ns
30. Social activity	ns	ns	ns
31. Relative's expectation	ns	ns	ns
32. Level of free time activity	ns	ns	ns
33. Relative's satisfaction with 32	ns	ns	ns
34. Discrepancy of patient behavior and relative's expectation	ns	ns	ns

**Different from pre- post results*
ns-not significant, sig-significant at .05

On ten variables an analysis of pre- post and follow-up variables yielded results different from those obtained in the analysis of only pre- post differences. Only these differences will be further elaborated upon here.

1. Differences Among Groups

On four variables (11, 20, 21, and 27) the additional data indicated that the groups were not significantly different from each other. This is consistent with expectations that the three groups would do equally well.

2. Differences Over Time

On one variable, 3(K-MMPI), follow-up results indicate that the groups changed significantly over time although they had not demonstrated a significant change at post assessment. On one variable, 11 (Mania), they did not show significant change from pre- post follow-up although they showed significant change at post assessment. This indicates that the groups did not maintain their change over time. Graphs A and B indicate that the two experimental groups scored into the abnormal range on Mania following treatment but had returned to the normal range after a three-month period.

3. Interaction Effects

On eight variables interaction effects were different from those obtained with pre- post data 2(F-MMPI), 3(K-MMPI), 6(Hy-MMPI), and 27(Capacity for intimate contact-POI), interaction effects disappeared over time and the groups were not differentially affected by the treatments; this is consistent with expectations.

For the remaining four variables (14, 15, 17, and 22) the interactions were significant with follow-up data where they had been insignificant with only pre- post data. For these variables further statistical investigation yielded results as summarized in Table IX.

TABLE IX
SIGNIFICANT INTERACTIONS AT FOLLOW-UP
NOT PRESENT AT POST ASSESSMENT

Variable
14. Time incompetent - Group B did not retain full therapeutic gain.
15. Time competent - Not due to individual group differences.
17. Inner directed - Group B did not maintain full therapeutic gain.
22. Self-regard - Group B did not maintain full therapeutic gain.

Graphic presentations of these results indicate that, although the groups did not maintain full therapeutic gains, their scores still fell in the normal range and showed an improvement from pre-treatment assessment.

Further analysis of data showing pre- post differences over time, but not among groups, at follow-up showed that on Variable 16(Other directed-POI), Group B did not retain its improvement over time although Groups A and C did.

Summary of Follow-up Data Analysis

These results indicate that on 21 variables there is no interaction, that is, the groups were not differentially affected by the treatment conditions. On six variables, although the interaction is significant, it appears due to error variance. On the remaining variables this appears due, in four cases, to Group B's not retaining its change over time, whereas A and C groups did. On two variables, C changed more significantly than A or B and on one, B and C changed more than A. Table X presents a summary of the follow-up data analysis.

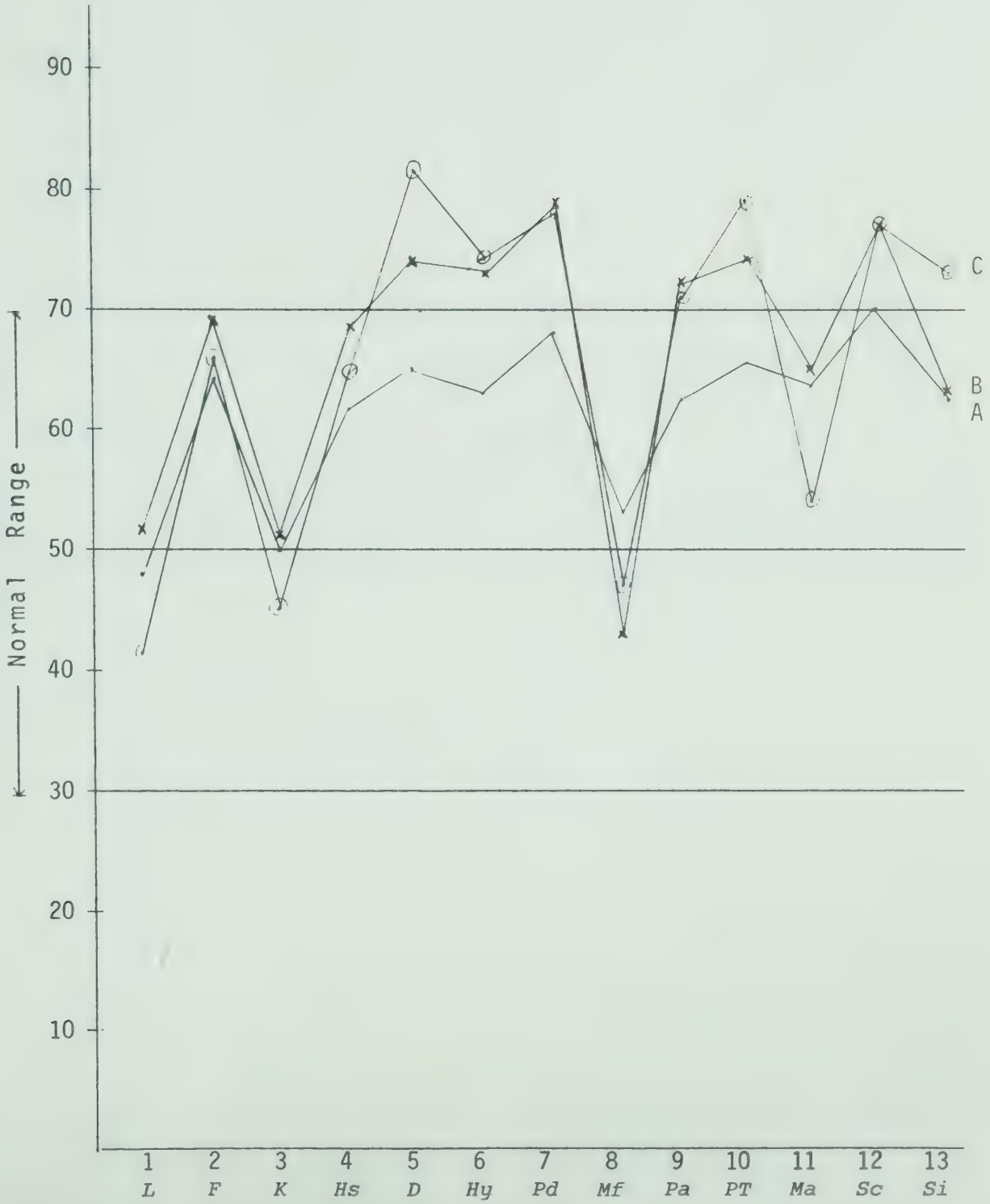
TABLE X
SUMMARY OF PRE- POST FOLLOW-UP DATA ANALYSIS

No change for any group from post to follow-up	on 28 variables.
Deterioration from post to follow-up for some groups	on 5 variables.
Improvement from post to follow-up for some groups	on 1 variable.

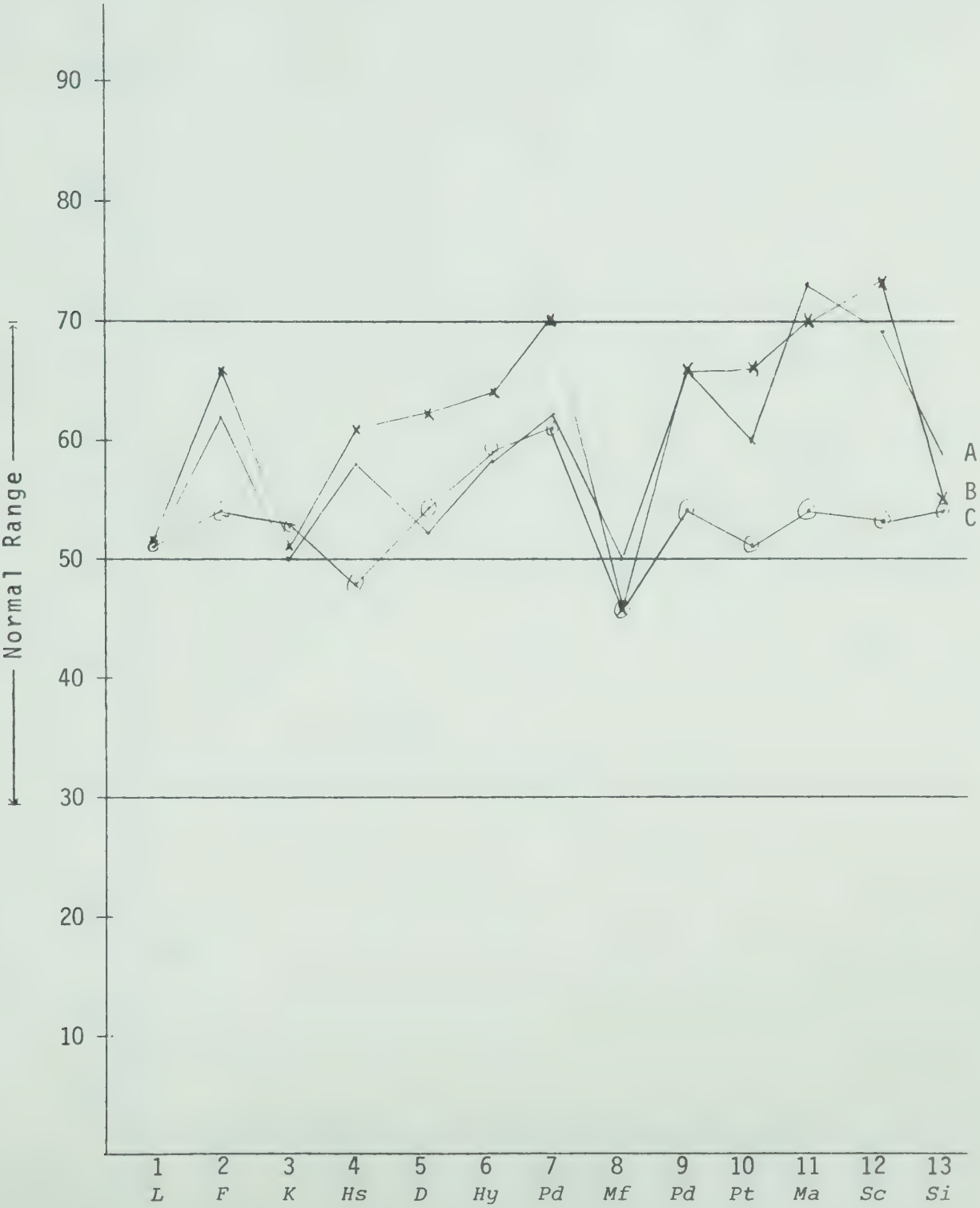
Graphical Presentation of the Data

Three graphs were plotted to depict the three groups on the MMPI at pre- post and follow-up. The normal range is delineated as expectations centered around scores in this range. See Graphs A, B and C. Three graphs were plotted to to show the POI results; see Graphs D, E and F.

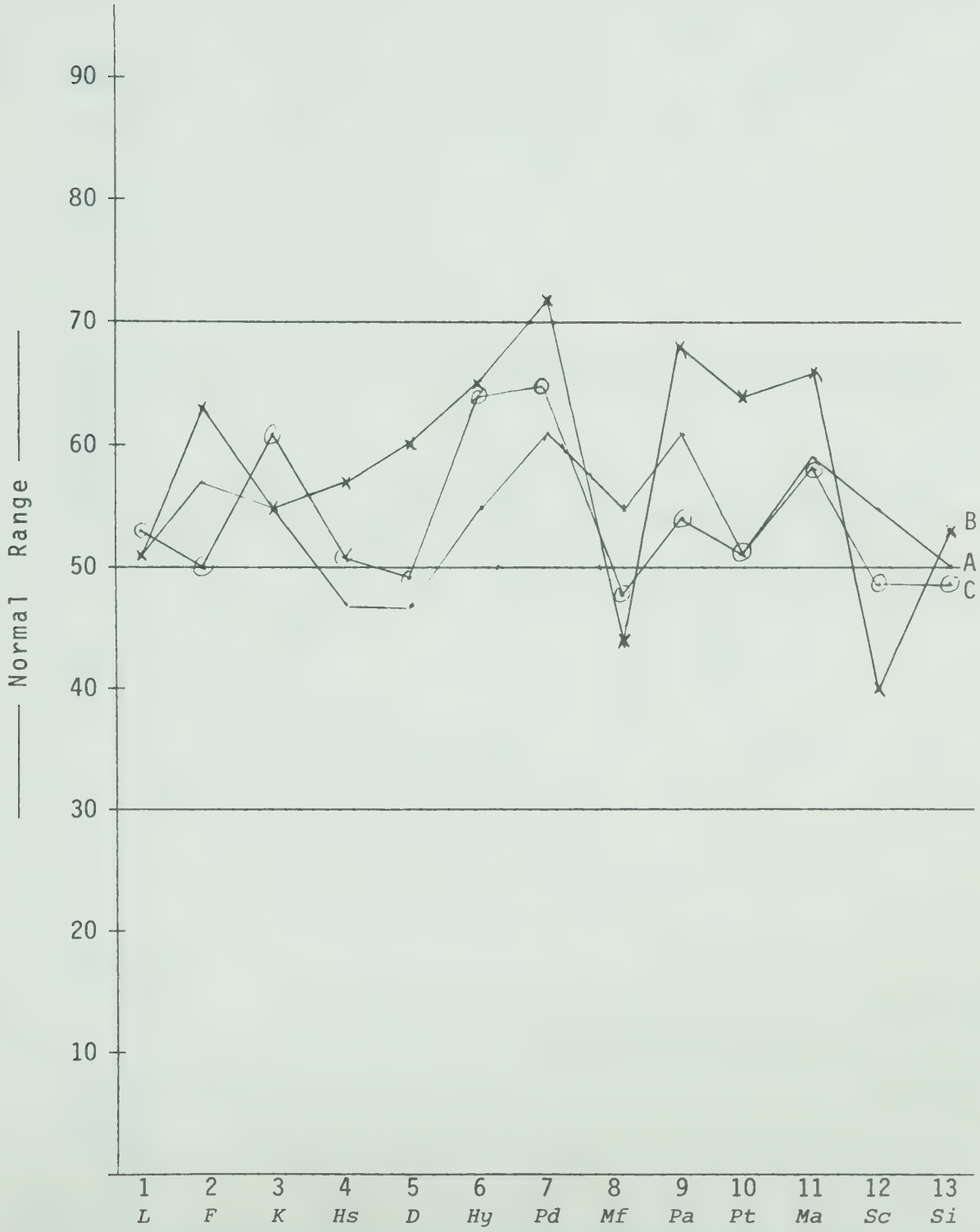
GRAPH A
MMPI: PRE-TEST SCORES FOR ALL GROUPS



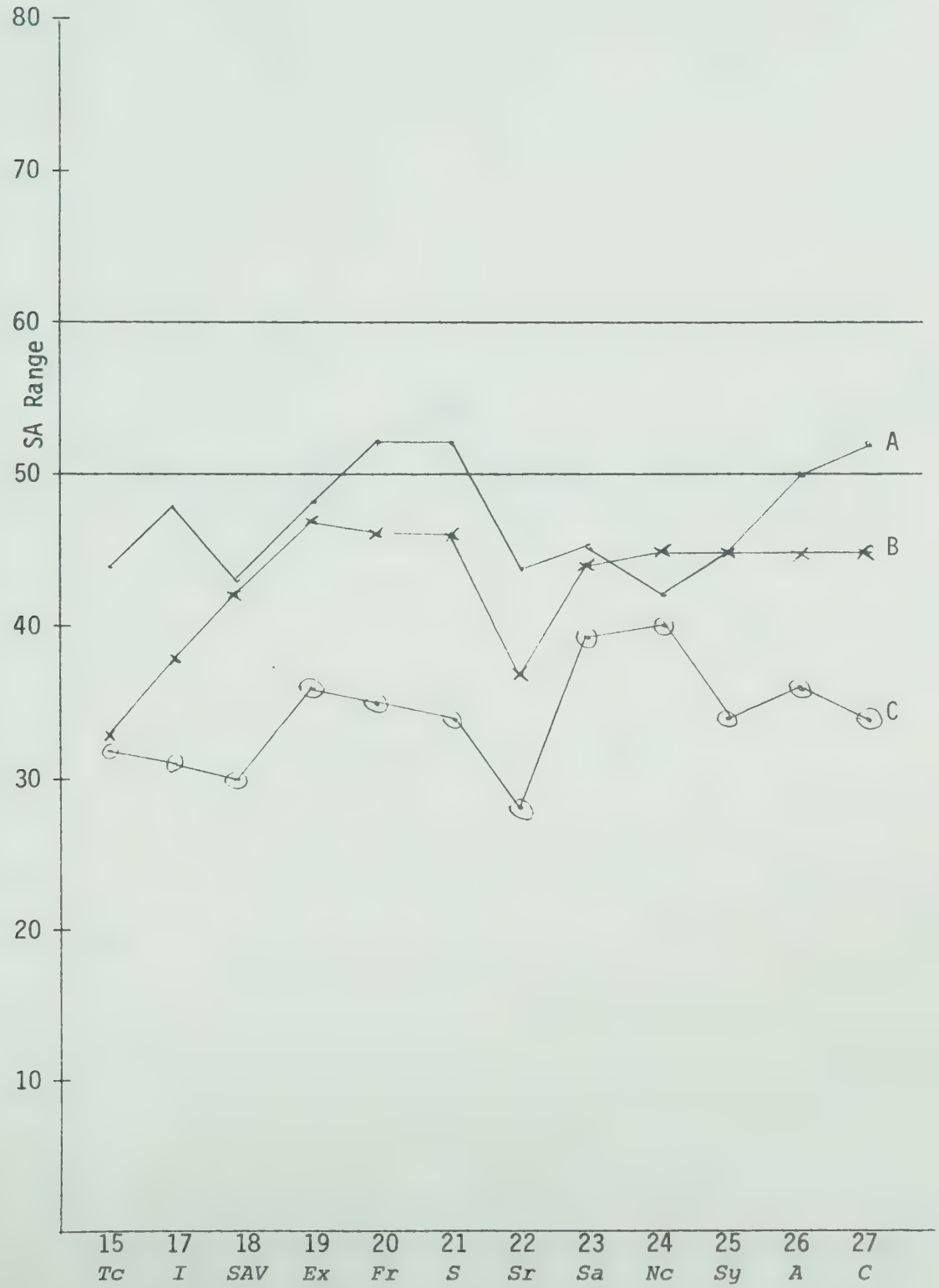
GRAPH B
MMPI: POST-TEST SCORES FOR ALL GROUPS



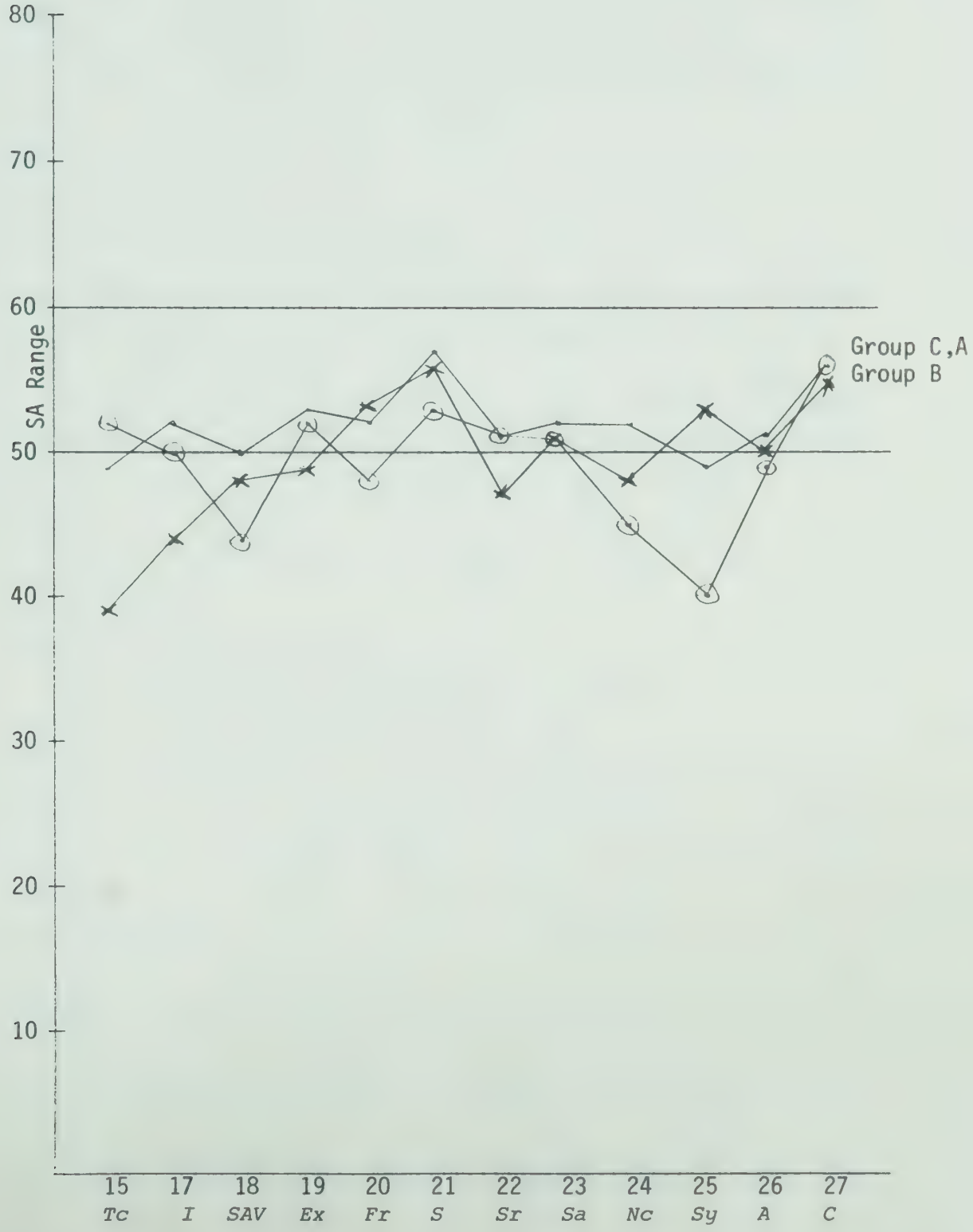
GRAPH C
MMPI: FOLLOW-UP TEST SCORES FOR ALL GROUPS



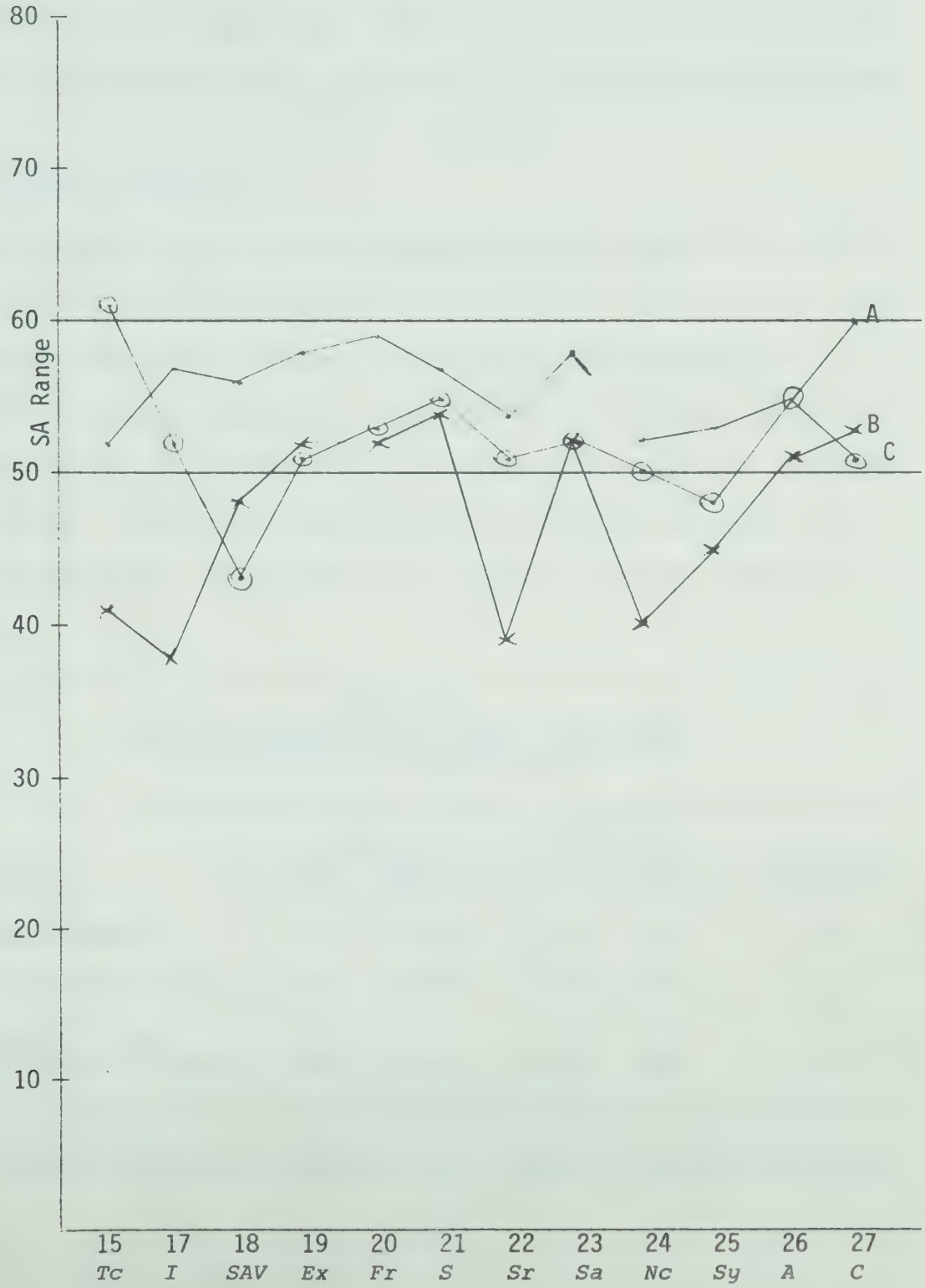
GRAPH D
POI; PRE-TEST SCORES FOR ALL GROUPS



GRAPH E
POI: POST-TEST SCORES FOR ALL GROUPS



GRAPH F
POI: FOLLOW-UP TEST SCORES FOR ALL GROUPS



Additionally, Graphs G to F_1 present the data for all groups over the time periods for variables individually where significance was obtained. The results on the Brief Psychiatric Rating Scale are presented on Graph E_1, and for Katz Scale 1 on Graph F_1. Other Katz data will not be presented as norms are not available for comparisons of scores.

Ancillary Findings

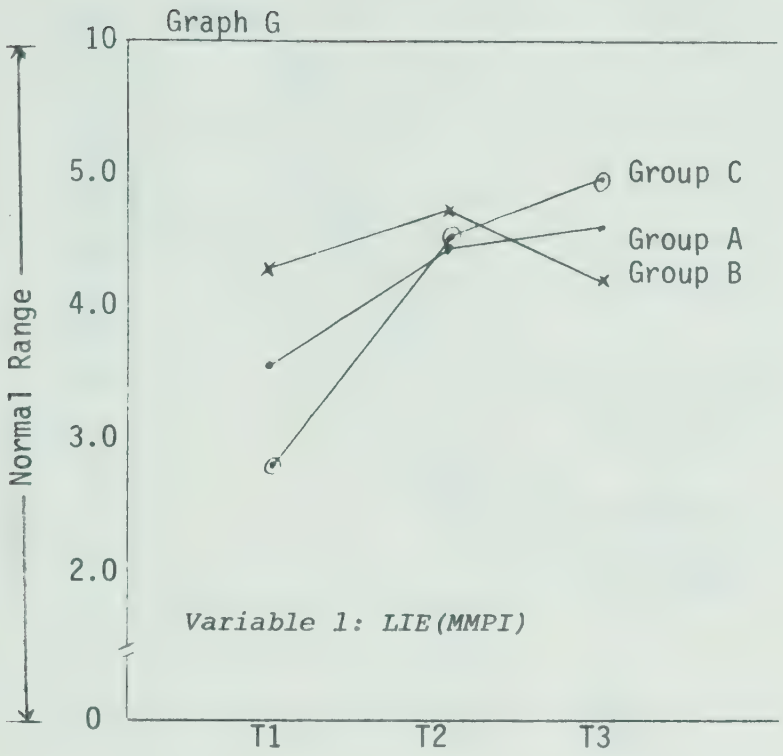
For interest's sake, some variables were chosen for evaluation of differences against two factors. Research does not indicate the effect of sex or of past psychotherapy on scores on change measures. Variables were chosen to assess differences, on the basis of the writer's personal bias and interests. Table XI presents data on three variables for sex differences (comparing only persons in the encounter groups).

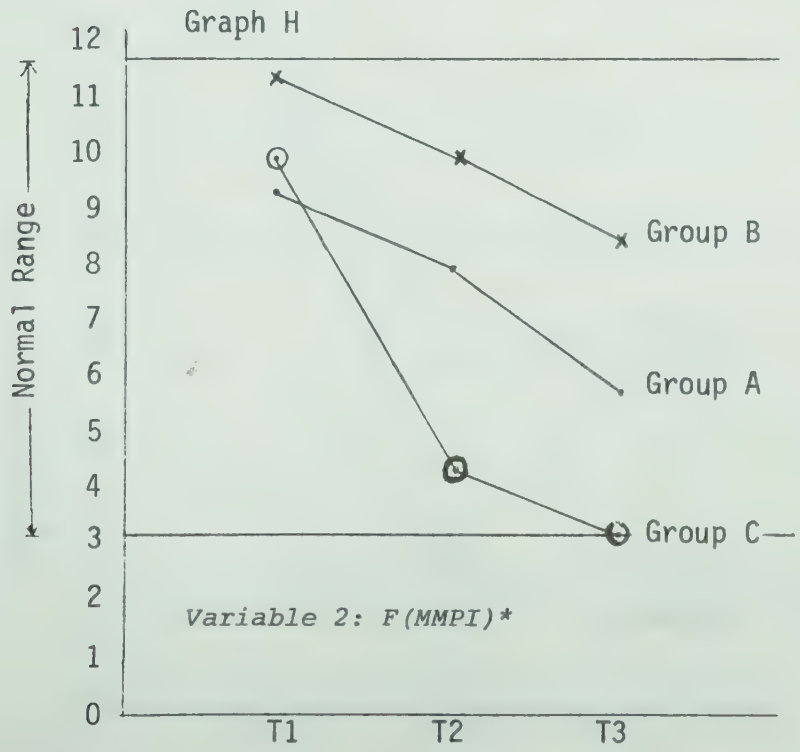
TABLE XI
SEX DIFFERENCES ON THREE VARIABLES
(Encounter Groups Only)

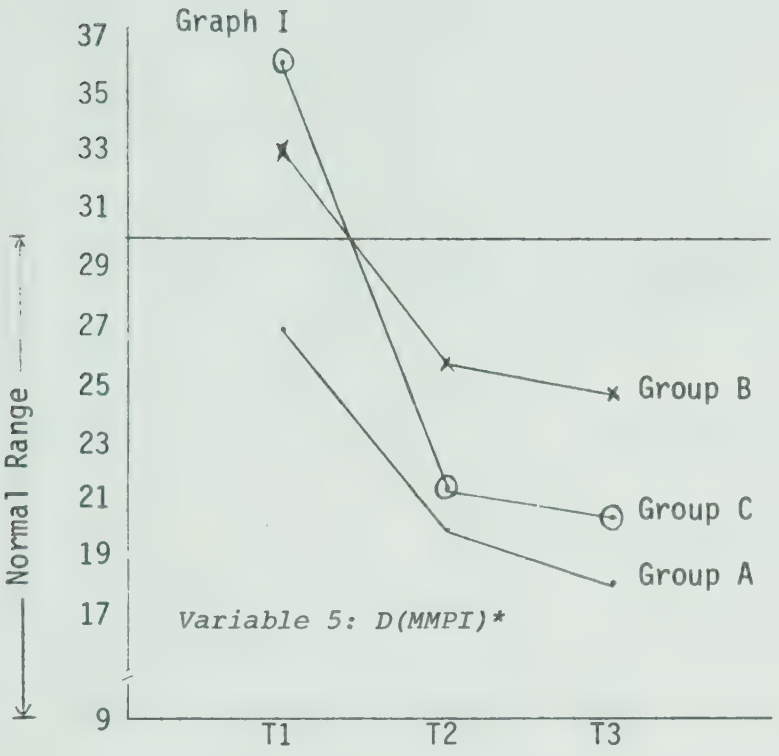
Variable	*Means*		*Standard Deviation*		*Sig of Difference*
	Male	*Female*	*Male*	*Female*	
21. Spontaneity	13.5	13.45	2.59	2.91	ns
23. Self-acceptance	15.9	14.30	1.75	3.36	ns
27. Capacity for intimate contact	18.9	17.8	3.35	3.89	ns

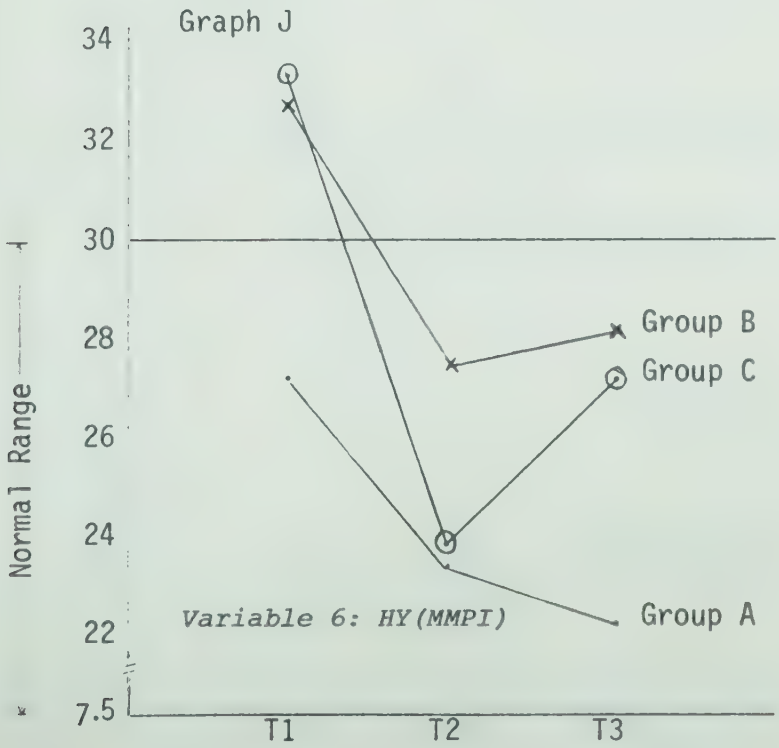
No differences between sexes were found on these variables.

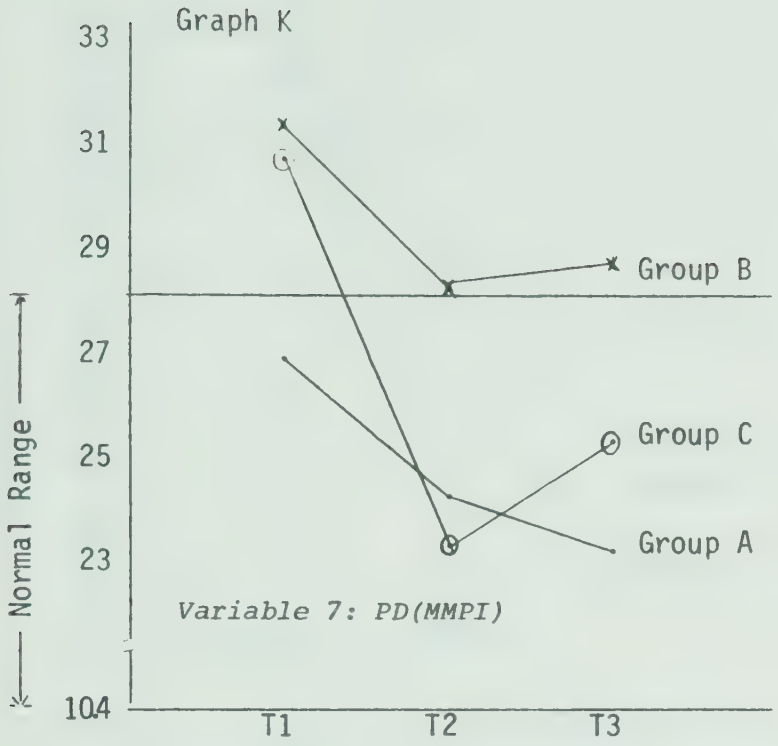
GRAPHIC PRESENTATIONS FOR VARIABLES
WHERE GROUPS CHANGED SIGNIFICANTLY
**Significant Interactions Present*






Graph I
37
35
33
31
29
27
25
23
21
19
17
9
Normal Range
Group B
Group C
Group A
Variable 5: D(MMPI)*
T1
T2
T3


Graph J
34
32
30
28
26
24
22
7.5
Normal Range
Group B
Group C
Group A
Variable 6: HY(MMPI)
T1
T2
T3


Graph K
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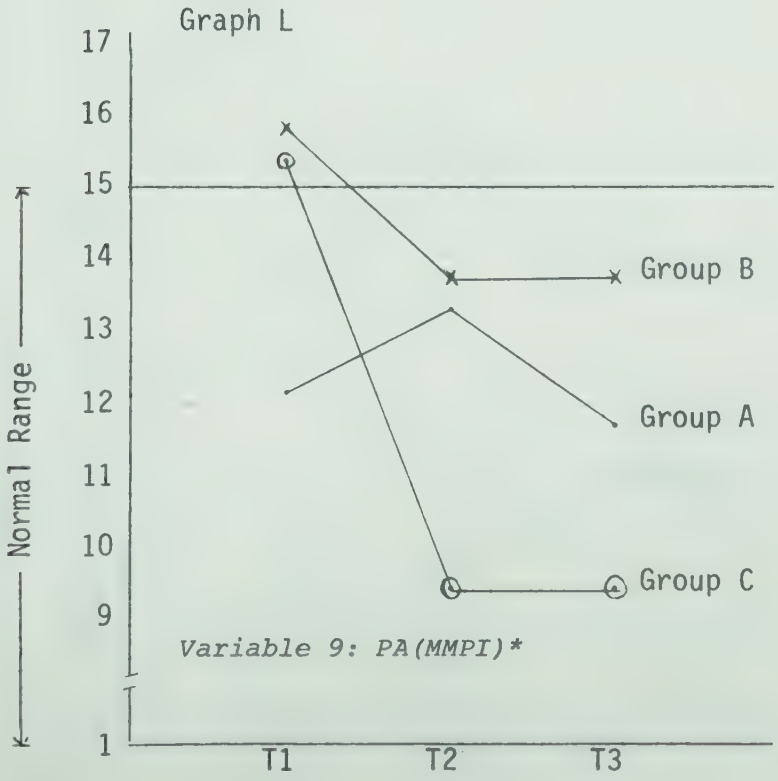
31
29
27
25
23
104
Normal Range
Group B
Group C
Group A
Variable 7: PD(MMPI)
T1
T2
T3


Graph L
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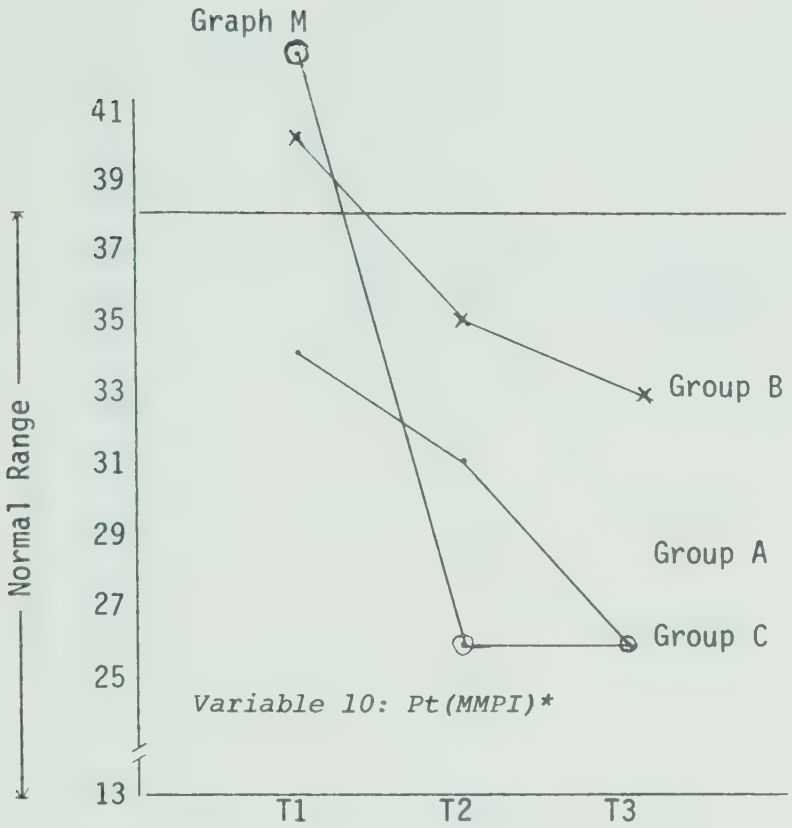
16
15
14
13
12
11
10
9
1
Normal Range
Group B
Group A
Group C
Variable 9: PA(MMPI)*
T1
T2
T3


Graph M
41
39
37
35
33
31
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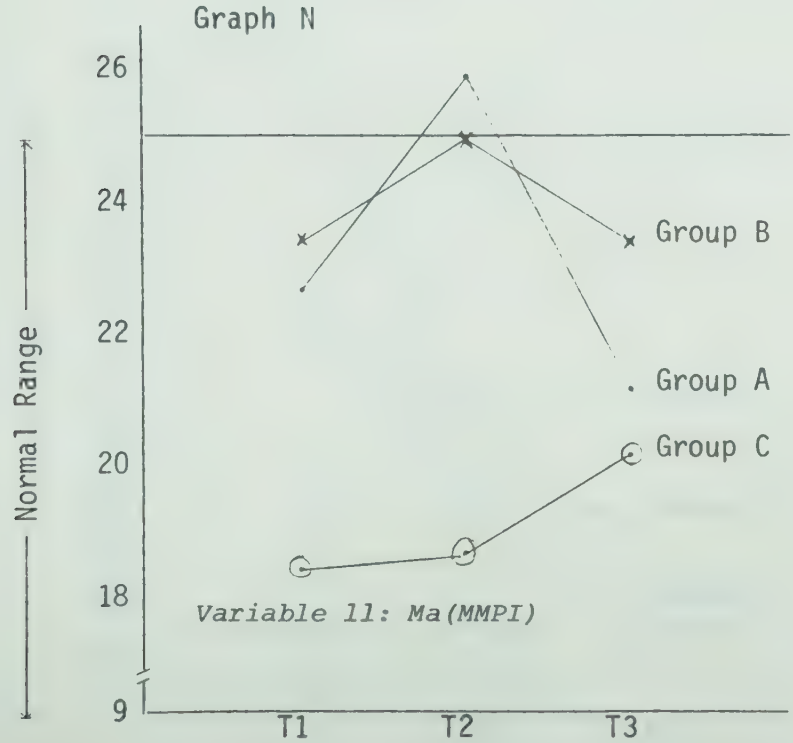
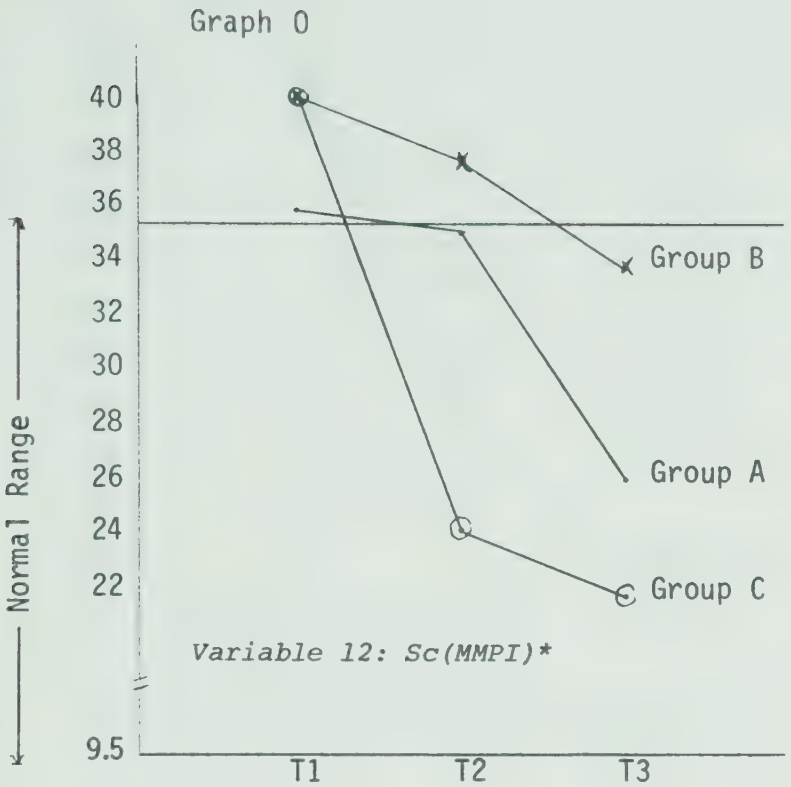
27
25
13
Normal Range
Group B
Group A
Group C
Variable 10: Pt(MMPI)*
T1
T2
T3


Graph N
26
24
22
20
18
9
Normal Range
Group B
Group A
Group C
Variable 11: Ma(MMPI)
T1
T2
T3


Graph O
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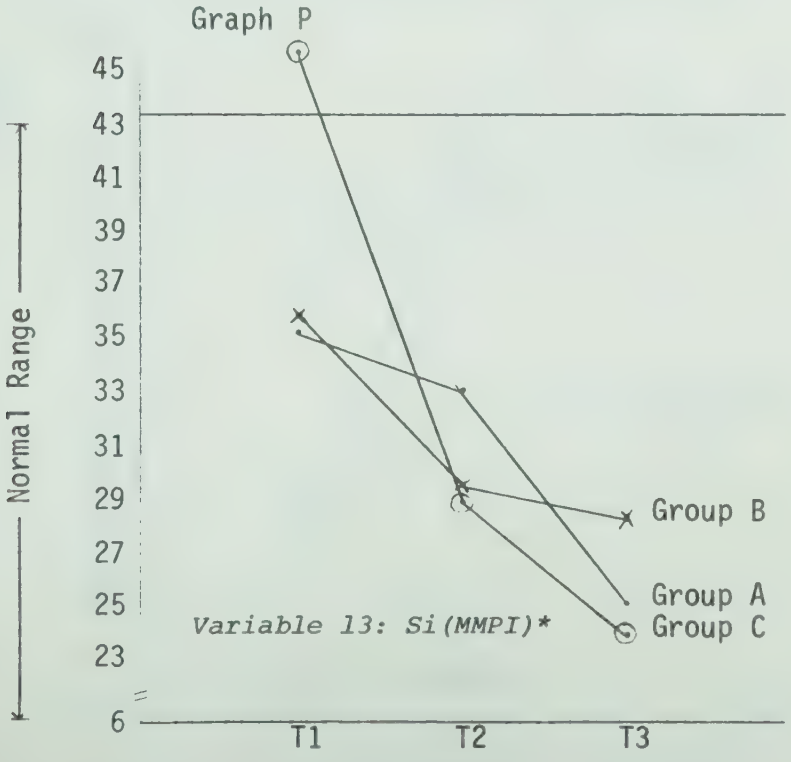
38
36
34
32
30
28
26
24
22
9.5
Normal Range
Group B
Group A
Group C
Variable 12: Sc(MMPI)*
T1
T2
T3


Graph P
45
43
41
39
37
35
33
31
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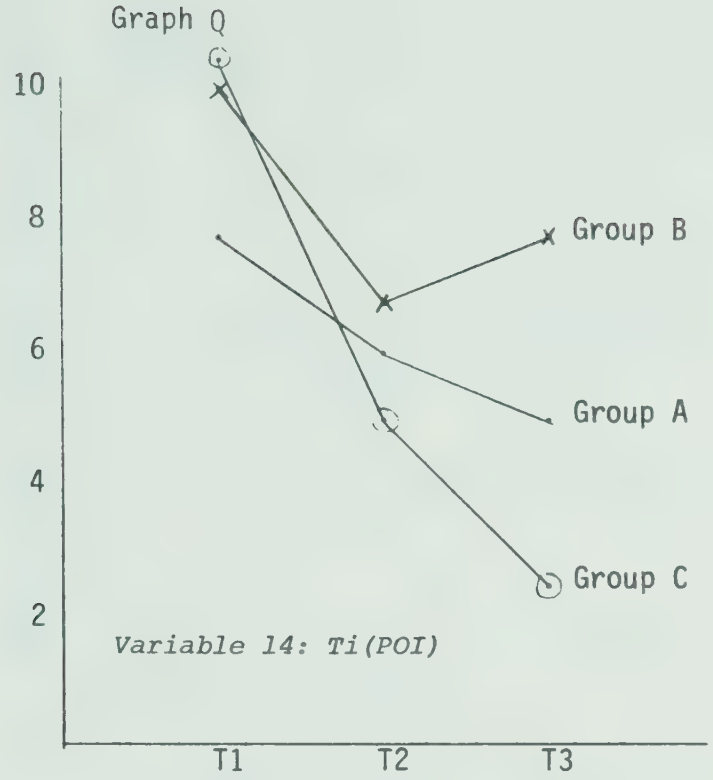
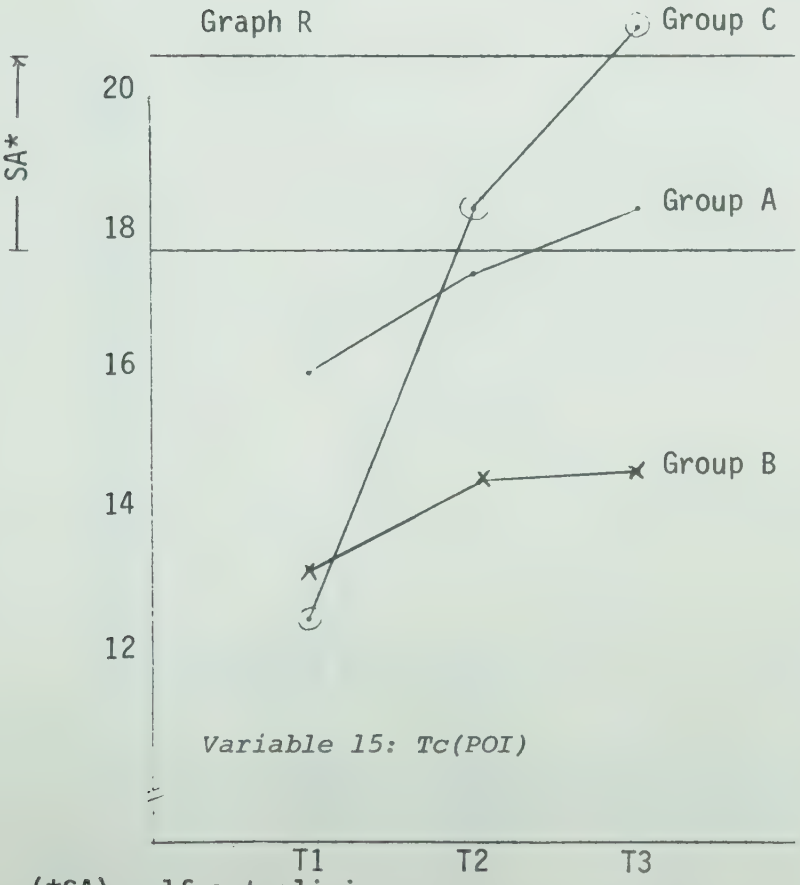
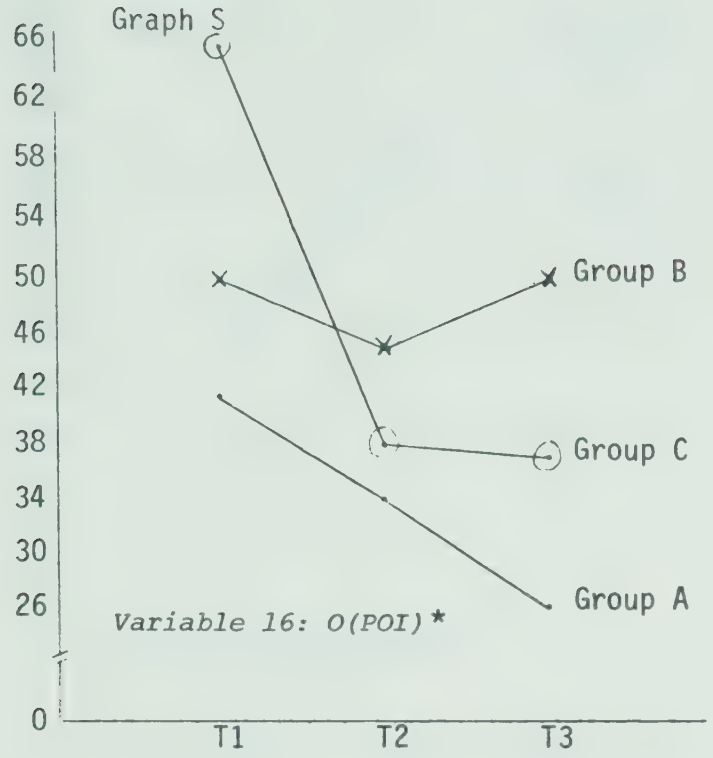
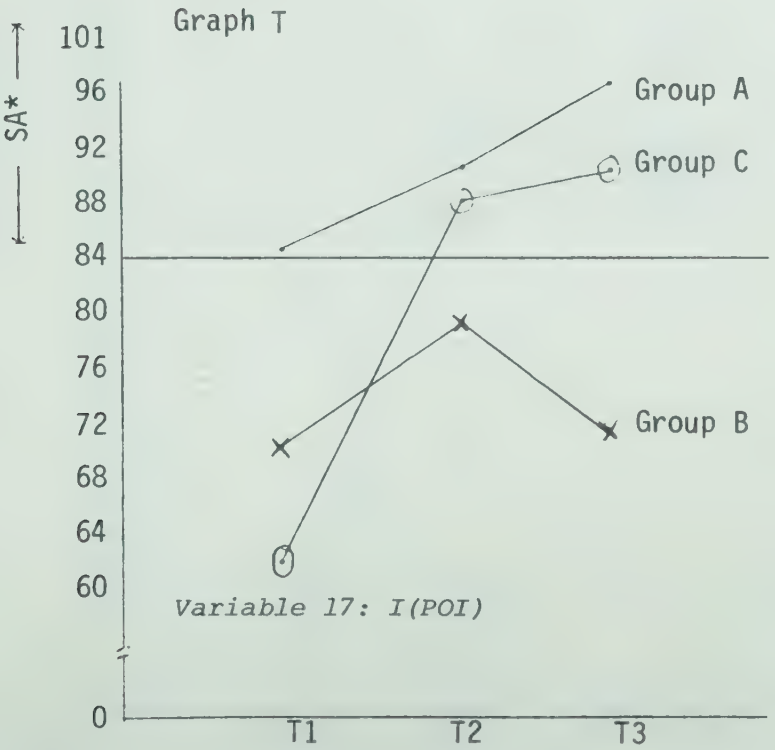
25
23
6
Normal Range
Group B
Group A
Group C
Variable 13: Si(MMPI)*
T1
T2
T3



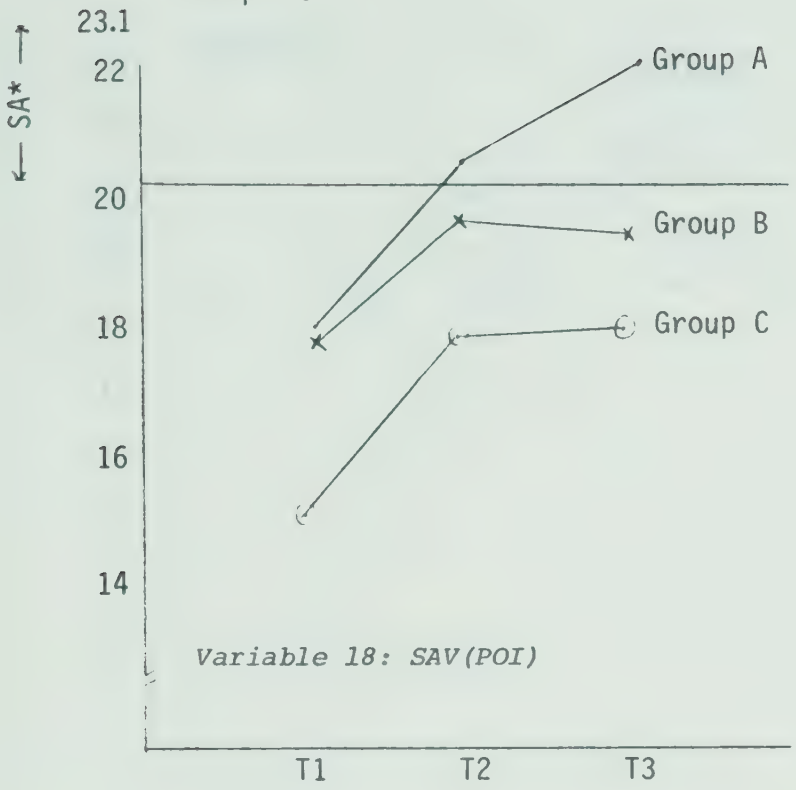


(*SA) self-actualizing range

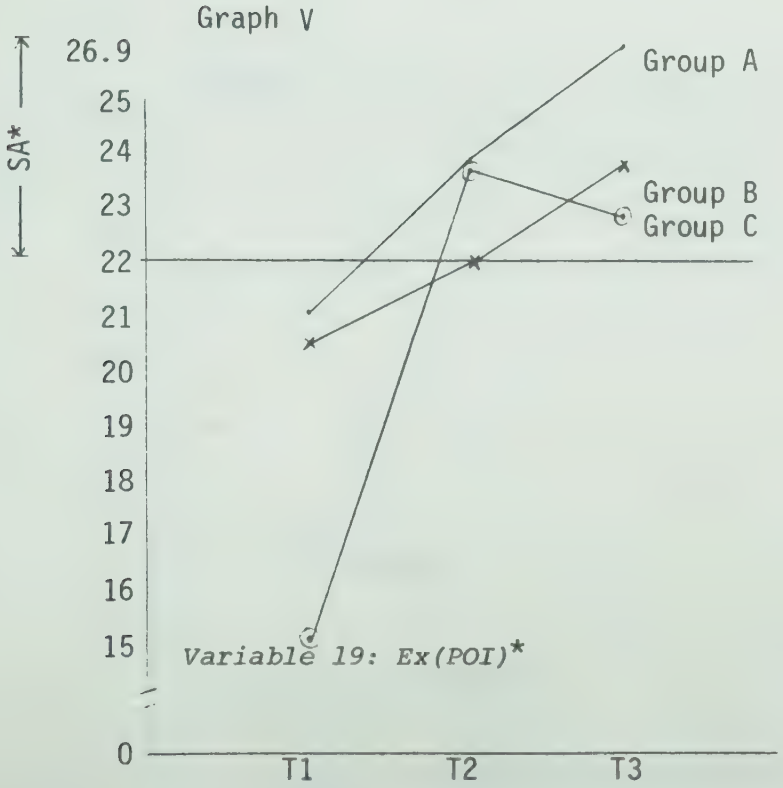

Graph S
66
62
58
54
50
46
42
38
34
30
26
0
T1
T2
T3
Group B
Group C
Group A
Variable 16: O(POI)*

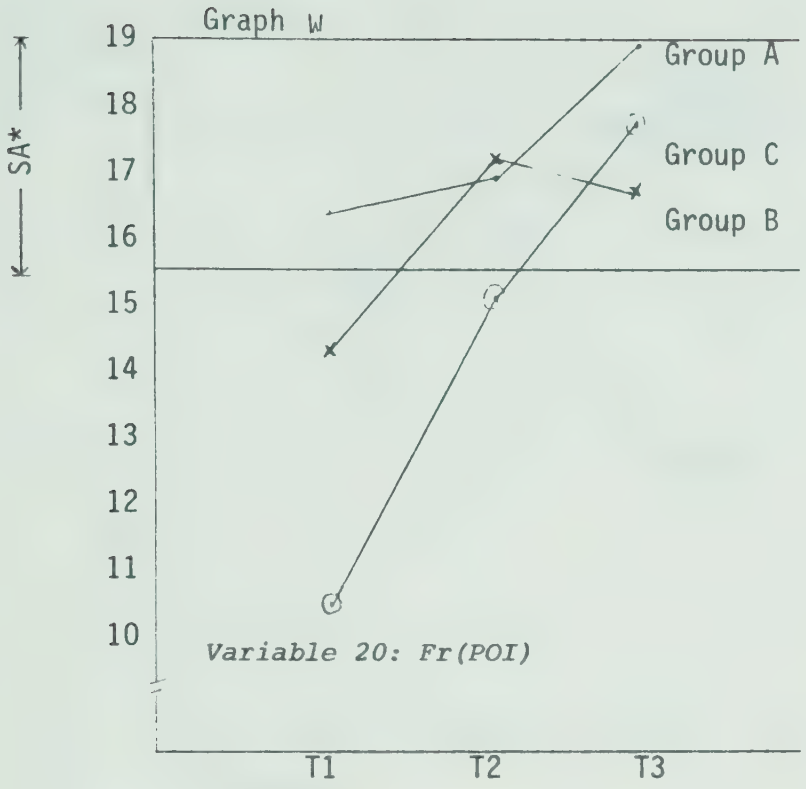

Graph T
SA*
101
96
92
88
84
80
76
72
68
64
60
0
T1
T2
T3
Group A
Group C
Group B
Variable 17: I(POI)

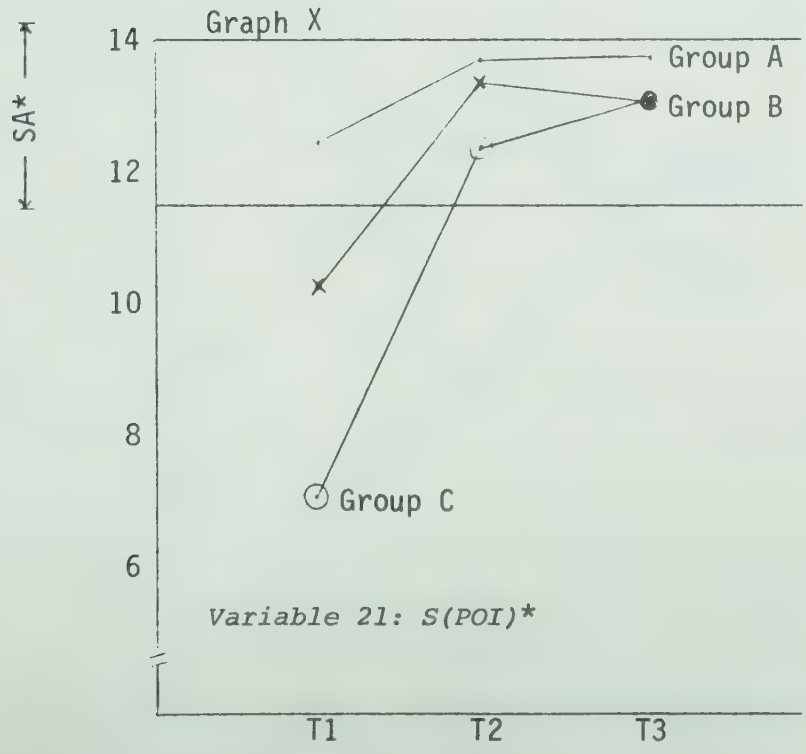
Graph U



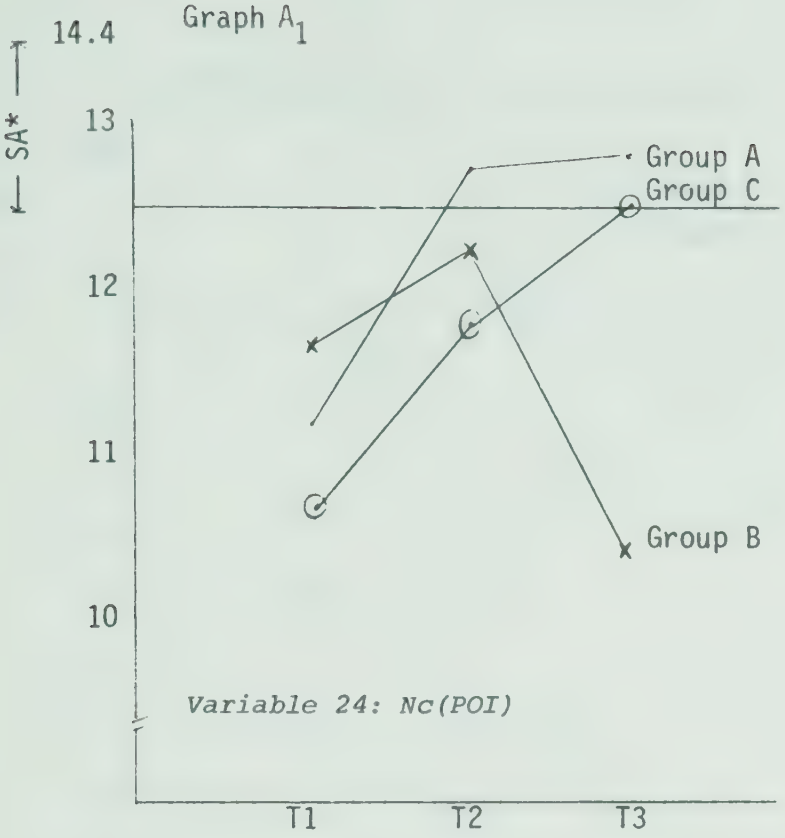
Graph V



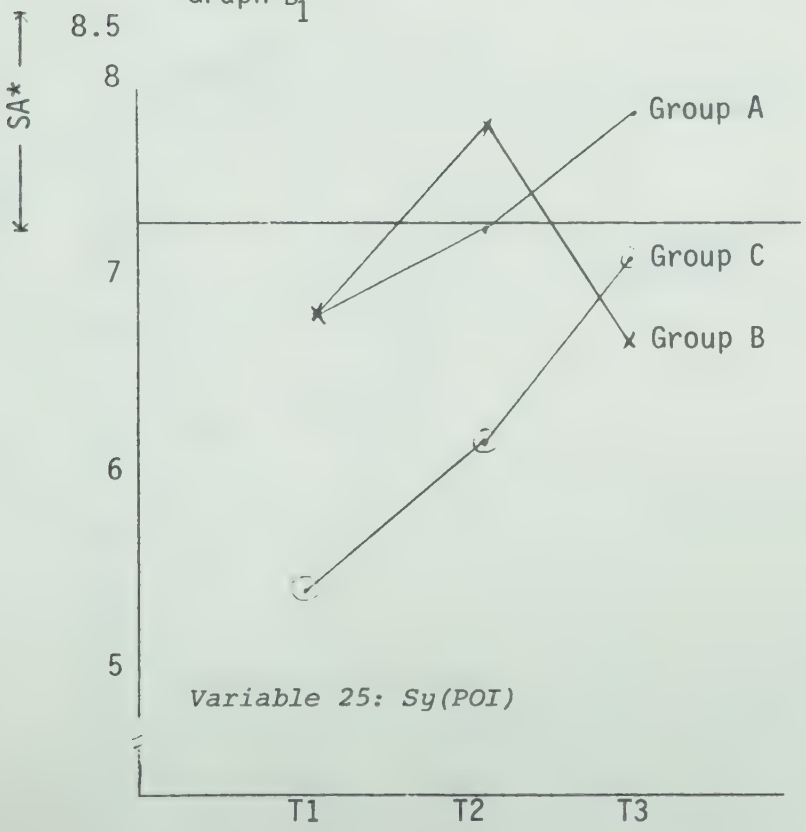

Graph W
SA*
19
18
17
16
15
14
13
12
11
10
Group A
Group C
Group B
Variable 20: Fr(POI)
T1
T2
T3

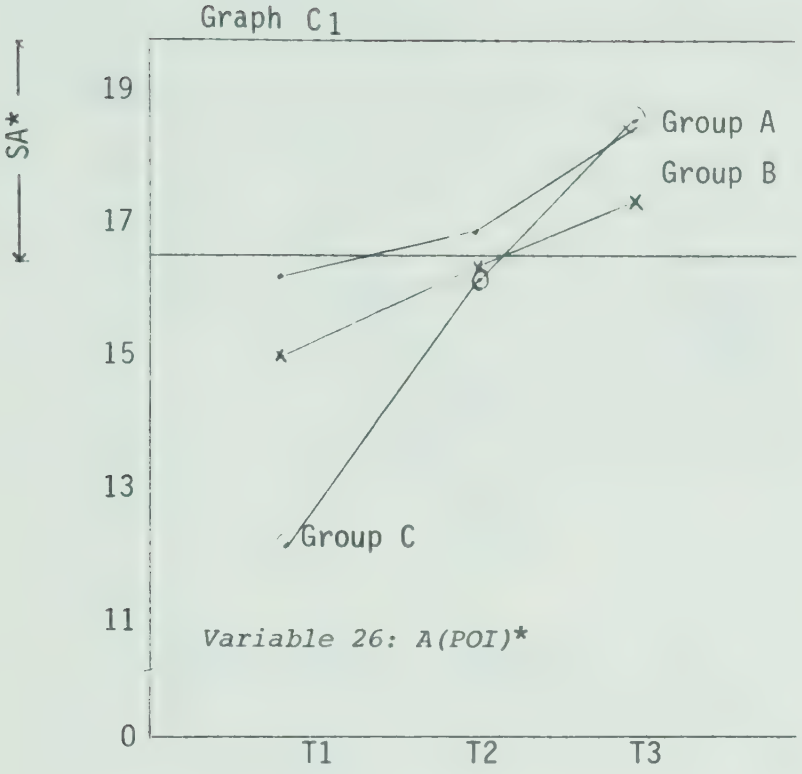

Graph X
SA*
14
12
10
8
6
Group A
Group B
Group C
Variable 21: S(POI)*
T1
T2
T3

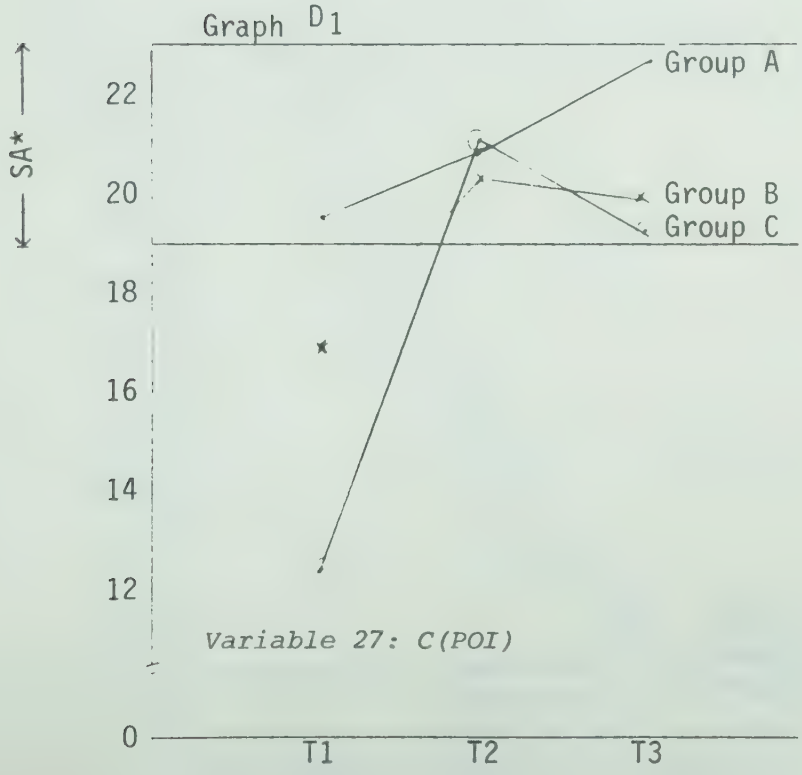
Graph A_1



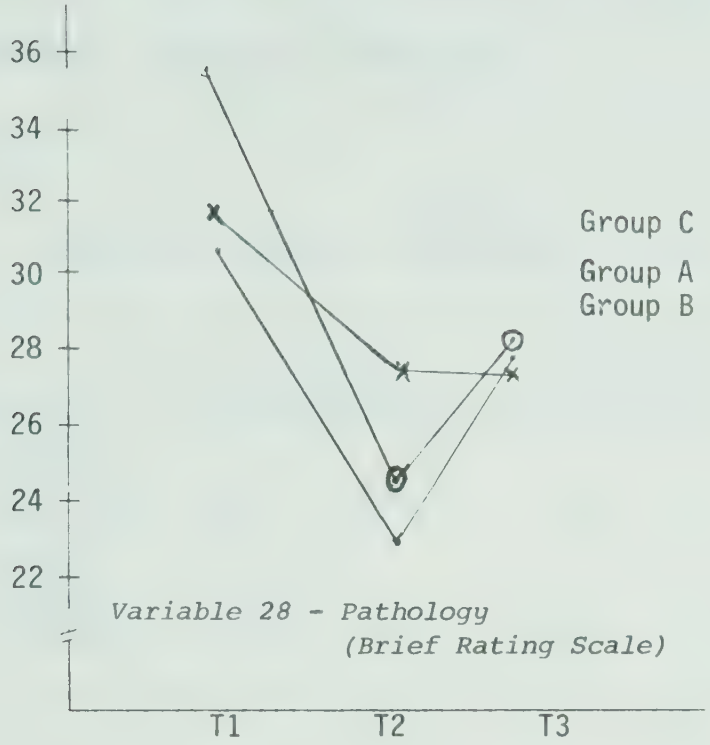
Graph B_1




Graph C1
SA*
19
17
15
13
11
0
T1
T2
T3
Group A
Group B
Group C
Variable 26: A(POI)*


Graph D1
SA*
22
20
18
16
14
12
0
T1
T2
T3
Group A
Group B
Group C
Variable 27: C(POI)

Graph E_1



Graph F_1

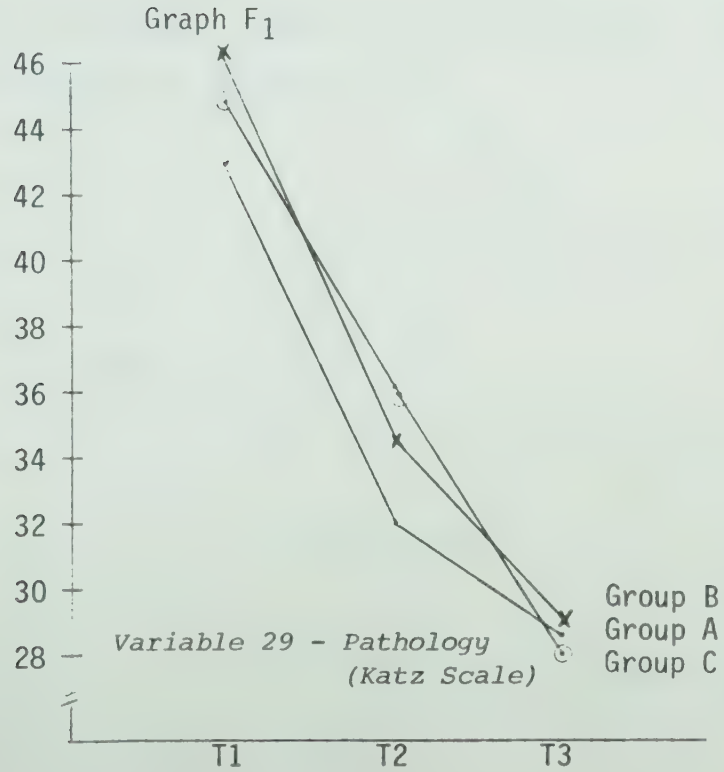


Table XII presents data on two variables for differences between persons with less than six months previous psychotherapy and those with more than six months previous psychotherapy (using all subjects).

TABLE XII
PREVIOUS THERAPY DIFFERENCES ON TWO VARIABLES

Variable	*Means* 0-6mos	6mos-+	*Standard Deviation* 0-6mos	6mos-+	*Significance of Difference*
28. General pathology	29.3	24.5	4.27	.81	ns
29. General psycho-pathology	34.7	33.3	4.82	7.3	ns

No differences were found on these variables among subjects who had limited previous psychotherapy (up to six months) and those who had more.

Demographic Information

Information was obtained from all subjects prior to participation in treatment conditions. (See summary in Table XIII.)

TABLE XIII
DEMOGRAPHIC INFORMATION ON SUBJECTS

1. Sex
   - *Male* 3A, 3B
   - *Female* 5A, 5B, 7C
2. Age
   - *25 years* 4A, 2B, 3C
   - *25-35 years* 3A, 5B, 3C
   - *35 years-+* 1A, 1B, 1C
3. Marital Status
   - *Single* 3A, 3B, 1C
   - *Married* 2A, 4B, 4C
   - *Divorced* 3A, 1B, 2C
4. Salary of Household
   - *-$5,000* 4A, 2B
   - *$5-10,000* 2A, 2B, 5C
   - *$10-15,000* 2A, 4B, 2C
5. Education
   - *Junior High* 1A, 1B
   - *High School* 4A, 5B, 6C
   - *Some University* 1A, 1C
   - *University Graduate* 2A, 2B
6. Previous Psychiatric Hospitalizations
   - *0* 5A, 6B, 7C
   - *1* 3A
   - *2* 1B
   - *3* 1B
7. Previous Office Psychotherapy
   - *None* 5C
   - *-6mos* 2A, 1B
   - *6mos-1 year* 4A, 3B, 2C
   - *More than 1 year* 2A, 4B
8. On Medication at Start of Treatment
   - *Yes* 2A, 2B, 2C
   - *No* 6A, 6B, 5C
9. Had Previous Group Therapy
   - *Yes* 1A, 2B
   - *No* 7A, 6B, 7C

Additional information obtained at follow-up is presented in Table XIV

TABLE XIV
DEMOGRAPHIC INFORMATION AT FOLLOW-UP

1. Visits Psychiatrist
   - *No* 3A, 3B, 3C
   - *Regularly* 1A, 3B
   - *Occasionally* 4A, 2B 2C
2. Number of Psychiatrist Visits
   - *0* 3A, 6B, 3C
   - *1* 2A, 1B, 2C
   - *2* 1A
   - *3* 2A
   - *4* 1B
3. Medication (still on)
   - *More* 0
   - *Less* 1A, 1B
   - *Same* 1B, 1C
   - *None* 7A, 6B, 4C
4. Sessions with Group Leader or at Hospital
   - *Yes* 7B
   - *No* 8A, 1B, 5C
5. Change in Marital Status
   - *Yes* 1A, 1B
   - *No* 7A, 7B, 5C
6. Change in Job
   - *Yes* 4A, 3B, 2C
   - *No* 4A, 5B, 3C
7. Extent Group Influenced Change
   - *Great Deal* 2A, 1B, 1C
   - *Slightly* 2A, 1B, 1C
   - *Not at all* 1A, 1B
8. Effect of Treatment
   - *Very Great +* 4A, 5B, 2C
   - *+* 3A, 1B, 2C
   - *Slight +* 1A, 2B, 1C

On only one variable does there appear to be a difference in post group behavior among the groups. This is on sessions with leaders where B group met for two sessions. Analysis of variance indicated the differences among groups at follow-up and will not be repeated here. The groups appear to be distributed comparably on all other variables.

Inter-Judge Rating Reliability

In order to ensure that the raters for the Overall and Gorham Brief Psychiatric Rating Scale had attained satisfactory reliability prior to testing subjects for this study, a series of six trial interviews was completed. Judges worked in pairs, as explained under the Methodology section. Percentage of agreements was calculated for each pair yielding an underestimate of reliability and is presented in Table XV. (A one-point discrepancy was considered agreement.)

TABLE XV
PERCENTAGE OF AGREEMENT AMONG JUDGES

Trial	*Pair 1*	*Pair 2*	*Pair 3*
	%	%	%
1	93.75	56.25	93.75
2	100.0	93.75	93.75
3	93.75	81.25	75.0
4	81.25	68.75	100.0
5	100.0	87.5	87.5
6	93.75	100.0	100.0

The above results indicate that there was acceptable reliability among judges in the pairs.

Matching of Leader Style with his Self-Description

Four persons had matched four anonymous descriptions of the group leaders to the styles they observed on video tapes of the leaders in randomly selected sessions of the group experiences. Table XVI presents results of the accuracy of their matches and the leaders' styles.

TABLE XVI
MATCHING OF LEADER STYLE AND SELF-DESCRIPTION

Judge I	*Judge II*	*Judge III*	*Judge IV*
50%	100%	100%	100%

It was concluded that the leader's self-description was accurate and that these styles were depicted in their behavior in the groups.

CHAPTER SIX

DISCUSSION AND SUMMARY

Discussion of Results of Hypothesis Testing

Hypothesis 1 - On 26 of 34 variables measured, the three groups changed significantly from pre- to post treatment. On 25 variables the move was in a positive direction - towards the normal or towards the self-actualizing range. There was no significant change on 8 variables.

The treatment situations were all effective in enhancing the personal function of the subject groups. In other words, the treatment conditions were a positive growth experience for the participants. This is supportive of the hypothesis of this study and is also consistent with the findings of Bunker (1965) and Gibbs (1971) and Schutz (1971) who obtained significant positive changes with participants in T-Groups or encounter groups. Cordova and Marcetti (1971) suggest that this is due to the encounter group providing a setting for "self-disclosure, acceptance, respect, genuineness, empathy, understanding, warmth, support, freedom to express feeling, responsible confrontation, a non-defensive posture towards those who challenge one's behavior, concreteness of communication, translation of self into non-cliche language, a refusal to flee demand and sometimes painful interaction - behaviors that constitute or lead to human growth" (p 11). Perhaps these factors are also central to

the therapy process and are basic to the positive change observed in the control group as well. Since the amount of time required to achieve these changes in the day-patient group was nine times as long as the time required to achieve them in the encounter group, there is an advantage in terms of time economics for participants in encounter groups.

A second possibility is that the encounter group and the day-patient hospitalization program were only as effective as no treatment and that the obtained differences are due to merely the passage of time as Eysenck's (1960) writings suggest. Since data are not available in this study on a comparable 'no treatment' group, it is not possible to rule this possibility out on experimentally based arguments. Turning, however, to the scant amount of relevant research where comparisons between no treatment and 'treatment' groups is available [Argyris (1965), Cooper and Maugham (1971), Rubin (1967)] it was found that the encounter group produces significantly greater changes in a positive direction than occurs with persons who have no treatment experiences. On the basis of this argument it is proposed that the three conditions of this study were effective change agents.

Change occurred towards the normal or self-actualization on 25 variables, away from the norm on 1 variable, and not at all on 8. This may be due to the following: (refer to Table III for labels for variables).

On variables 3(K-MMPI), 4(Hs-MMPI) and 8(Mf-MMPI), all pre- post scores fall within the normal range, hence one would not expect significant change to occur here which would have resulted in movement out of that range; that is, in the abnormal or subnormal direction. It is suggested that, on the MMPI assessed variables, it is likely that, where the initial scores fell in the normal range, there would not be a significant change. Viewing Graph A, it is apparent that on five variables (2, 3, 4, 8, and 11), the pre-test scores fell in the normal range. In three of these (3, 8 and 11), no significant change was observed after treatment. The above rationale suggests a possible explanation for these findings. For the remaining two variables, 2(F-MMPI) and 5(Hs-MMPI) although pre-test scores were in the normal range, significant change was observed after treatment. For 2, this may be due to the relationship the F scale has demonstrated with many of the clinical scales. As they all changed significantly it may be that the factor common to the dynamics of clinical disturbance, and a tendency to exaggerate or fake, was responsible for this joint movement. For Hs (Variable 5) it is noted pre-test scores closely approach the abnormal range, hence, may have been more extensively affected by the treatments leading to significant change whereas the other pre-test scores in the normal range, which did not change, were more definitely in the normal range, leading one to expect less change.

The remaining five variables, wherein no significant change occurred (30 to 34, inclusive), were all obtained from the Katz Scale for Social Adjustment. Although the relative had rated significant change in the subject's pathology scores (Variable 29), they did not rate their level of social behavior, use of free time, or their own expectations of these behaviors significantly changed. Several possibilities for these findings exist. Firstly, relatives indicated that they had some difficulty in understanding the instructions to the test, particularly regarding where they were to rate patient behavior and where they were to indicate their own expectations of the patient. This may invalidate the scores and explain the results. An alternate possibility is that the patient's disturbance did not affect his social behavior or how he spent his free time. His pathology may have expressed itself in his moods, his interpersonal behavior and not necessarily in the areas measured by the 2 scales on the Katz. Further study would be required to establish the answer to this question. The third possibility is that, since discrepancies between relative's expectations of patient's behaviors and use of free time was extremely low at pre-treatment assessment (Variable 34), again one would not expect significant change to occur after treatment. Relative did not indicate significant dissatisfaction with subject's social behavior or use of free time prior to treatment, hence, lack of significant change may be due to the subject's awareness of the other's acceptance of his behavior in these areas.

With no external pressure to change, he may feel no motivation or need for change on these variables.

The final variable considered in this hypothesis is the movement on the variable of Mania (11-MMPI) which was away from the normal for the two experimental groups. It is suggested that this may be due to the "high" that is subjectively reported as a consequence of the group experience, reflected on the mania scale. This variable measures energy level, activity and other factors which may be reflected by the participants who have just terminated an encounter group. This effect had disappeared at follow-up as is discussed in the following paragraph, further suggesting it is a temporary state immediately following the group experience.

The analysis of follow-up data further supported Hypothesis 1 indicating that, with one exception, the groups had maintained their significant changes. The exception is Mania (Variable 11-MMPI) and was considered to be a reflection of the participants' return to a normal state of excitement three months following the group which they had left feeling a "high". Maintaining positive gain over time is consistent with findings of Gibbs (1971) and Schutz (1971) who report the same effect in their results.

In summary, Hypothesis 1 is well supported by the data. In patients' self-assessment (MMPI and POI results), on all but three measures, there is significant positive change over treatments maintained over a three-month follow-up period. Clinicians' ratings (Variable 28-Brief Psychiatric Rating

Scale) depict the same positive movement. Relatives report a significant decrease in pathology (Variable 20). Possible explanations for these findings and contradictory findings have been offered.

Hypothesis 2 - On 30 of 34 variables measured, the groups were not significantly different. This is supportive of the hypothesis which postulated no differences among groups, i e, that the encounter groups would do equally as well or as poorly as the control condition of day-hospitalization. This finding is expected to be due to the therapeutic value of the encounter group being comparable to the therapeutic value of the traditional treatment program of day-hospitalization.

For the 4 variables wherein the groups were significantly different, 11(Mania-MMPI), 20(Feeling reactivity-POI), 21(Spontaneity-POI), and 27(Capacity for intimate contact-POI), possible explanations for these findings are presented individually for each variable.

1. Variable 11(Mania). Both experimental groups changed to a significantly higher degree than the control. In fact, both scores are on the border between normal and abnormal as opposed to C Group which is within the normal range. It is suggested that participants in the encounter group had a higher "energy level", etc, than those following the hospital experience. This disappeared at follow-up as was mentioned previously, hence, supports the hypothesis that the groups would not differ and that the encounter groups would do as well as control group.

2. Variable 20 (Feeling reactivity). On this variable Groups A and B reached a greater level of self-actualization than the control group - again supporting the second hypothesis. This may be due to encounter group participants' readiness to express their feelings because of the emphasis in a short period of time on this value. They do not receive contrary messages from the community as may be the case in day-patient programs. For groups in the encounter situation the environment is consistent and they may be able to achieve a higher level on some variables because of this.

3. Variable 21 (Spontaneity). Here, Group A achieved a more self-actualized level than the control group - again supporting hypothesis 2. This may be due to a more specific emphasis on spontaneity in the group setting as contrasted with the day-hospital. The control group, however, is within the self-actualized range at post assessment as well, indicating no large disparities.

4. Variable 27 (Capacity for intimate contact). Here the control changed significantly more than Group A but the two groups were at essentially the same place at post treatment time. The control had further to move on this variable.

These findings are consistent with Guinan and Foulds' (1970) research wherein they obtained significant changes in a group of students on these POI variables, following a marathon sensitivity training weekend. It may be that the encounter group provides an atmosphere allowing slightly more dimension for change than does a traditional treatment program.

Analysis of interaction effects related to hypothesis 2, however, indicated that, on six variables, the degree of change for each group was different. These are -

1. Variable 2 (Fake). The control group changed more than the experimental groups. This may be due to the clinical identification the patients had at admission which has been shown to affect F scores (Hathaway and Meehl, 1966), and which disappeared at discharge when the patients gave up their clinical identity.

2. Variable 5 (Depression). Here again the control changed more than the two experimental groups. This may be due to their initially more severe depression scores which may have led to greater change (probability was less than .10 and points out a trend not really a significant difference).

3. Variable 6 (Hysteria). Here the control changed more than did Group A (p less than .025), and more than Group B (p less than .10). B also changed more than A (p less than .10). Group A was in the normal range at pre-test and C and B required more change to move into the normal range. The results suggest only a trend in the direction of more improvement for the B and C groups.

4. Variable 9 (Paranoia). The control changed more than B (p less than .10). The control again had further to change to move to the normal and results suggest only a trend in that direction.

5. Variable 12 (Schizophrenia). The control group improved more than the experimental groups here. It may be

that the scale of schizophrenia which measures - among other things, individual style, non-conformity - was affected differently by the two treatment conditions. The philosophy of the encounter group may have encouraged some aspects of schizophrenic behavior such as individualistic thinking, which day-hospital (with its orientation to pathology) may have negatively reinforced. Further investigation of the question of similar behaviors being defined as bizarre and abnormal in one setting, being defined as individually acceptable and assertive of the individual's own style of thinking in another, must be undertaken to assess the likelihood of this possibility occurring.

6. Variable 21 (Spontaneity). Control and B group changed more than did Group A ($p < .025$). This may be due to again the control and Group B being more abnormal at pretest time and having further to move to arrive in the self-actualized range.

The writer of this paper adopts the position that subjects in therapeutic experiences will show the greatest change in areas where their disturbance or clinical pathology is most extreme. This seems self-evident in that persons will be most aware of areas where they suffer most extreme differences. They will very probably receive feedback from the helping others around these areas as they will appear most obviously. Other possibilities for the increased movement where more pathology exists, which occurred generally for the control group in this study, is that day-patient

hospitalization is more effective in reducing certain clinical symptoms. Although this argument cannot be invalidated by these data, it is suggested that it be questioned on the basis of the encounter group being an effective change agent in reducing scores from the abnormal range, particularly for Group B, to the normal. (See Graphs 5, 6, 9, 10, and 12.) Regression, practice effects and/or the passage of time may also explain these findings.

Follow-up data analysis further supports this hypothesis. On none of the variables were the final groups significantly different from each other.

Follow-up Data Analysis: Interaction Effects

Examination of the interaction effects on Table VIII indicates that on three variables 15 (Time competent-POI), 17 (Inner directed-POI) and 22 (Self-regard-POI), Group B did not maintain its change over time as did Groups A and C. On an additional four variables, (2-Fake-MMPI, 3-K-MMPI, 6-Hy-MMPI, and 27-Capacity for intimate contact-POI), the interaction effects present at post assessment had disappeared at follow-up and the groups did not display differential scores at this time.

In summary, the data strongly support Hypothesis 2. The groups did not behave differentially in the majority of cases. Exceptions to this finding indicate that on three variables Group B did not maintain change as well as did Groups A or the control. Although Group B did not maintain

its post treatment level, it only deteriorated to a level slightly less than A and C (p less than .10). This indicates a trend and is not necessarily a reliable difference among the groups. The effect that the two sessions with the leaders following the group had on this group may have been felt on the three variables where they did not retain their improvement. On the other hand, it may have been that the two encounter groups had a slightly different focus which cannot be assessed in view of this study's emphasis on outcomes rather than on process. The fact that on only three variables was there any differential effect on the groups leaves one to question whether this reflects real evidence of comparative effectivenesses of the groups. In view of the fact that it may be assumed that the three groups were homogeneous and that there are only slight differences among them at follow-up, it appears accurate to conclude that the encounter group has a therapeutic effect comparable to traditional day-hospitalization.

Discussion of Ancillary Findings and Recommendations for Further Research

Tables X and XI give results indicating that neither sex, nor amount of previous psychotherapy influenced the degree of change on selected variables. Further research to isolate factors that differentially affect therapeutic outcomes is warranted. Experimental investigation of encounter groups with more severely disturbed persons may be justified

on the basis of the positive value of the group experience for this sample. Other possibilities would be to investigate the effects of mixed patient and non-patient groups versus all non-patient or all patient groups. Many other factors may be examined to assess the most effective basis for selection of encounter group participants. The possibility exists that no screening is necessary and composition does not affect outcome on many variables.

Final Summary

The relevance of encounter groups for psychiatric patients is widely discussed in recent publications; experimental investigation, however, is scarce. This study constitutes an attempt to further information in this area. The major outcome of the study is finding a significant positive change in psychiatric patients who participated in a five-day residential encounter group. Outcome measures compared favorably with outcomes for a control group of day-patients. The results suggest that the encounter group may be a useful alternative treatment method for disturbed persons. Theoretical questions raised by this study relate specifically to treatment philosophies. If further research along the lines of this study differentiate populations wherein maximum benefit may be obtained in encounter group experiences, treatment settings alternate to hospital and clinical facilities may be required for the most effective and efficient treatment plan.

On the basis of this study, further investigation of these questions appears justified.

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APPENDIX A

CRITERIA FOR PATIENTS FOR ENTRY INTO ENCOUNTER GROUPS

CRITERIA FOR PATIENTS FOR ENTRY INTO ENCOUNTER GROUPS

PSYCHIATRIST A

1. Sufficient emotional strength.

2. Potential for emotional growth from such an experience.

3. No history of psychotic breaks or, if there is a history, re-examination by a psychiatrist who would give clearance that the patient has re-integrated sufficiently to benefit from an encounter group.

4. Age limits of between 20 and 40 years (approximately) for adults and between 14 and 18 years (approximately) for teenagers. These limits should not be used rigidly but could act as guidelines for grouping of clients in encounter groups.

5. Intellectual limits - my own feeling would be that IQ's should not vary by more than 20 points. Again, this is a rough rule of thumb, meant as a guideline rather than to be applied or adhered to rigidly.

6. If at all possible patients might be screened so that they could be grouped as to psychological or psychiatric sophistication - those with less sophistication of this sort being placed in one group and those with more sohpistication in another.

PSYCHIATRIST B

Include

1. Persons not able to cope with things at a feeling level.

2. Persons very hostile emotionally, unable to give or receive affection and relate well because of this.

3. Emotionally blocked and hostile persons.

4. Only persons with at least average intellect.

5. Obsessives, compulsives, intellectualizers, rigid and depressed persons.

6. Those at least 18 years of age.

Exclude

7. Persons whose hostility is related to homosexuality.

8. Psychotics.

9. Those with poor controls, suicidal and sexually acting-out persons.

PSYCHIATRIST C

Include

1. Psychosomatic disorders.

2. Reactive type of depression with a high level of anxiety.

3. Personality disorder (mild hysterics, mild obsessionals, anxiety states.

Exclude

1. Psychopathic personality disorders.

PSYCHIATRIST D

Include

1. Persons with no history of schizophrenic or manic episodes.

2. Persons not judged borderline schizophrenic or manic.

Exclude

1. Those whose life pattern has shown inadequate reality testing, i e, have seemed unable to learn from experience or responses are habitually inappropriate to situations.

2. Severe obsessionals or compulsive ruminators.

3. Those whose affect seems supercilious and laugh too easily in situations where most would not laugh.

4. Persons with no sense of humor.

PSYCHIATRIST E

Include

1. Most neurotics with adequate impulse control.

2. Medication is OK.

Exclude

1. Psychotics.

2. Paranoids.

3. Persons under 18.

APPENDIX B

OBJECTIVES FOR ENCOUNTER GROUP

OBJECTIVES FOR ENCOUNTER GROUP

TRAINER A

My philosophy of Encounter Groups is to help participants see themselves as others see them, and learn the difference between intention and their actions which may not be congruent with their intentions or wishes.

To help participants see that assumptions about others and about the intentions and actions of others may not be valid as a base for response until assumptions have been checked.

To help participants learn the fundamentals of communication skills to enhance their meaningful contact and mutual understanding of those closest to them, and to be able to discriminate with what others it is important for them to communicate accurately at some depth.

To help participants arrive at an acceptance of the responsibilities and privileges they alone bear for their actions and for the responsibilities and opportunities they have to conduct the course of their lives, while simultaneously respecting the similar rights and opportunities of others.

To help participants through the development of these attitudes and to assist in the development of these attitudes, to be able to confront themselves and their feelings more openly and to be self-disclosing selectively and freely to those others with whom they determine relationships are important.

To help participants learn not to be expressively judgmental of themselves or their close others. To help them learn by these means an increased self-confidence, ensuring ability to be more tolerant and understanding of others thus becoming better able to negotiate stressful life situations.

To help participants learn by these means to release and employ their innate creativity to their service and greater personal fulfillment.

The means to work toward these goals include helping participants in a group situation to deal with each other and selves as they are experienced at the moment, to facilitate attention being directed to their awareness of their attitudes and feelings, allowing free ventilation of their reactions and, if necessary, how these reactions arose, without specifically engaging in a depth inquiry of motives, history, or analytic investigation of unconscious attitudes or defenses. To help participants work out those current attitudes which prevent assumption of responsibility for themselves, and encourage them to become aware of and express their feelings, both re selves and others.

To this end my participation is that of a catalyst, observing the strengths and weaknesses of the individuals

in their tolerance to stress and attempting to gauge confrontation so as to keep within their ability to handle anxiety constructively. Principal participation is to encourage others to deal with each other and with me less as a tutor or authority (except in situations involving structured exercises) and more as a well-intentioned kindly facilitator.

TRAINER B

As a general objective I hope to facilitate the development of awareness of 'self' in others. I believe that with increased awareness new choices become apparent for participants concerning their interpersonal style, etc. Exploring new behavior patterns may then lead to more personal satisfaction.

I also hope to facilitate the development of meaningful interaction among participants. I believe that misunderstanding or miscommunication accounts for a great deal of human conflict and pain. I hope to help bridge the communication gap.

Another personal goal is that group members be left with some knowledge and skills which help them develop their own awareness, and help them to establish and maintain more meaningful relationships.

In view of these general goals I tend to use some of the following methods in groups.

- Feedback - In developing awarenesses, I encourage feedback among participants and focus on constructive feedback, i e, specific vs general descriptive vs evaluative, etc. Also, the concept of contracting for feedback.

- Use of Communication Skills - I use Wallen's communication skills extensively - I believe they help in bridging communication gaps and serve as a 'model' of an alternative communication style.

- Short Theory Inputs - From time to time I introduce some theory when I believe it will help clarify issues which evolve in the group. These short theory inputs are usually focussed on some dynamic of human interaction.

- Structured Exercises - I sometimes use them to have participants practice a new skill or to generate information about themselves.

- My main focus is generally on developing or encouraging a self-awareness process and facilitating the use of communication skills. In this respect I may give a direct educational input - a teaching intervention - or I may do some on-the-spot coaching to have the participants explore an alternative mode of contact.

- I generally respond to a group member's "feeling" state and try to convey, through reflection and paraphrasing, a sense of acceptance and support. I also tend to disclose my own feelings concerning a given interaction which may lead, on occasion, to some form of confrontation.

TRAINER C

My method to help the individual to become more genuinely and uniquely human when it is appropriate, is -

- be there in such a way that I'm not in the way,

- to facilitate encounters among individuals in the group,

- to utilize group resources, including the co-therapist,

- my technique is eclectic, including self-disclosure, when appropriate, viz modelling,

- I have a responsibility to exercise judgment when someone's defence systems or limited resources are being threatened.

TRAINER D

One of my basic aims is to assist the individual in exploring how his perceptions, behaviors and attitudes affect the way he is experiencing himself and others. As the person discovers how he depresses himself, makes himself feel guilty, or whatever, he may then feel more free to take responsibility for other modes of experiences that may alter his habitual style of experiencing.

For instance, an individual may interpret himself as "not being a good conversationalist", as "having difficulty making friends", and thus respond to his own definition of himself by disliking himself or others with whom these defined inadequacies seem to occur. Thus, the personal experiences of such people often become obsessed with covering or

falsifying experience in attempts to cover or falsify to self or others the ugly definition that the individual has placed on himself. However, engaging in covering or falsifying behavior reinforces the original notion of "I dislike myself as I am", and the cycle goes on and on.

One goal of therapy may be to interrupt the cycle by allowing the individual to be aware of it, exploring not only his own definition of himself, e g, not being a good conversationalist but also how he feels about not being a good conversationalist, e g, that people will not like him.

With increased awareness, the individual may experience less intensity of self-dislike as he shares what he has been trying to hideor falsify with others, and perhaps discover that others' responses to his "secret" are not as fantasized. Also, the future of covering or hiding becomes altered through awareness of the process, exposure, reactions of others, and possible desensitization to the issue through verbalization and redefinition.

My 'techniques' involve some of the Gestalt therapy methods of focussing on awareness and responsibility. In general, I often intervene to take the focus from "how other people and my terrible circumstance cause me to feel. . ." to focussing on the individual's responsibility for his reactions (definitions, perceptions, behaviors) to his situations. On many occasions stressful themes which occur in day-to-day living occur in the group setting, perhaps in relation to other group members. When this occurs, I prefer a "here and now" focus rather than dealing with the individual's historical report of 'what happens out there'.

APPENDIX C

M M KATZ AND S B LYERLY
RELATIVE'S BOOKLET

M M KATZ and S B LYERLY

RELATIVE'S BOOKLET

Preliminary to administration of the separate inventories, the examiner should paraphrase the following to the relatives: The forms which I shall ask you to fill out are designed to give us some idea of how _____ is from day to day, his behavior and how he gets along with other people. It will give us some idea of what he has been doing and how well he has been getting along since his return home.

Form R1: Relative's Rating of Patient Symptoms and Social Behavior

The examiner reads the following to the relative - There are a number of statements on this list which describe different kinds of behavior and mood. These include symptoms that people who have been in the hospital sometimes show. Would you go through them and indicate how he has looked to you during the past few weeks on these things. Alongside each statement are four possible answers. If, in your opinion, he is never like this or only rarely, then circle the number (1). If he is this way sometimes but not too frequently, circle the number (2). If he is like this often, circle the number (3). Circle the number (4) if the statement would describe _____ or his behavior always or practically always. For example, where the statement reads "has trouble sleeping", if _____ is sometimes bothered by this, then you would circle the number (2). If as far as you know he never or very rarely has any difficulties sleeping, then you would circle the number (1).

Do not spend too much time on any one question but make sure you check every question.

Form R2: Level of Performance of Socially-expected Activities

Instructions to the relative: People differ in what they are able to do after they come home from the hospital. I would like you to go through this list and tell me which of these things he has done or is doing since his return. For example, if he is not helping with the household chores, you would circle the number (1). If he helps some, then you would circle the number (2). If he is doing this regularly, then circle the number (3).

Form R3: Level of Expectations

Instructions to the relative: Families differ in what they think their relatives should do after they come home from the hospital. Now let's go back over the list. I want you to tell me which of these things you expected _____ to do within a reasonable time following his return. For example, if you expected _____ to be regularly helping with the household chores on his return, then circle the number (3). If you didn't expect him to be doing any of this, then circle the number (1).

Form RS4: Level of Free-time Activities

Instructions to the relative: What does he (she) do with his free time? I want you to go through this list and tell me which of these things he is now doing. For example, if he frequently works in and around the house, circle the number (1). If he does this sometimes, circle the number (2). If he never, or almost never does it, circle the number (3). Be sure to circle one of the numbers after each item.

Form R5: Level of Satisfaction with Free-time Activities

Instructions to the relative: Are you satisfied with the way he spends his free time? Let's go through the list again and this time indicate whether you would like to see him doing more or less of these things.

TABLE 1

KATZ ADJUSTMENT SCALE ITEMS (KAS) FORM R1:
RELATIVE'S RATING OF PATIENT SYMPTOMS
AND SOCIAL BEHAVIOR

Scale Format			
1 almost never	2 sometimes	3 often	4 almost always

1. Has trouble sleeping.
2. Gets very self-critical, starts to blame himself for things.
3. Cries easily.
4. Feels lonely.
5. Acts as if he has no interest in things.
6. Is restless.
7. Has periods where he can't stop moving or doing something.
8. Just sits.
9. Acts as if he doesn't have much energy.
10. Looks worn out.
11. Feelings get hurt easily.
12. Feels that people don't care about him.
13. Does the same thing over and over again without reason.
14. Passes out.
15. Gets very sad, blue.
16. Tries too hard.
17. Needs to do things very slowly to do them right.
18. Has strange fears.
19. Afraid something terrible is going to happen.
20. Gets nervous easily.
21. Jittery.
22. Worries or frets.
23. Gets sudden fright for no reason.
24. Has bad dreams.
25. Acts as if he sees people or things that aren't there.
26. Does strange things without reason.
27. Attempts suicide.
28. Gets angry and breaks things.
29. Talks to himself.
30. Acts as if he has no control over his emotions.
31. Laughs or cries at strange times.
32. Has mood changes without reason.
33. Has temper tantrums.
34. Gets very excited for no reason.
35. Gets very happy for no reason.
36. Acts as if he doesn't care about other people's feelings.

37. Thinks only of himself.
38. Shows his feelings.
39. Generous.
40. Thinks people are talking about him.
41. Complains about headaches, stomach trouble, other physical ailments.
42. Bossy.
43. Acts as if he's suspicious of people.
44. Argues.
45. Gets into fights with people.
46. Is cooperative.
47. Does the opposite of what he is asked.
48. Stubborn.
49. Answers when talked to
50. Curses at people.
51. Deliberately upsets routine.
52. Resentful
53. Envious of other people.
54. Friendly.
55. Gets annoyed easily.
56. Critical of other people.
57. Pleasant.
58. Gets along well with people.
59. Lies.
60. Gets into trouble with law.
61. Gets drunk.
62. Is dependable.
63. Is responsible.
64. Doesn't argue (talk) back
65. Obedient.
66. Shows good judgment.
67. Stays away from people.
68. Takes drugs other than recommended by hospital or clinic.
69. Shy.
70. Quiet.
71. Prefers to be alone.
72. Needs a lot of attention.
73. Behavior is childish.
74. Acts helpless.
75. Is independent.
76. Moves about very slowly.
77. Moves about in a hurried way.
78. Clumsy; keeps bumping into things or dropping things.
79. Very quick to react to something you say or do.
80. Very slow to react.
81. Gets into peculiar positions.
82. Makes peculiar movements.
83. Hands tremble.
84. Will stay in one position for a long period.
85. Loses track of day, month or year.
86. Forgets his address or other places he knows well.
87. Remembers the names of people he knows well.
88. Acts as if he doesn't know where he is.

89. Remembers important things.
90. Acts as if he's confused about things; in a daze.
91. Acts as if he can't get certain thoughts out of his mind.
92. Acts as if he can't concentrate on one thing.
93. Acts as if he can't make decisions.
94. Talks without making sense.
95. Hard to understand his words.
96. Speaks clearly.
97. Refuses to speak at all for periods of time.
98. Speaks so low you cannot hear him.
99. Speaks very loudly.
100. Shouts or yells for no reason.
101. Speaks very fast.
102. Speaks very slowly.
103. Acts as if he wants to speak but can't.
104. Keeps repeating the same idea.
105. Keeps changing from one subject to another for no reason.
106. Talks too much.
107. Says that people are talking about him.
108. Says that people are trying to make him do or think things he doesn't want to.
109. Talks as if he committed the worst sins.
110. Talks about how angry he is at certain people.
111. Talks about people or things he's very afraid of.
112. Threatens to injure certain people.
113. Threatens to tell people off.
114. Says he is afraid that he will injure somebody.
115. Says he is afraid that he will not be able to control himself.
116. Talks about strange things that are going on inside his body.
117. Says how bad or useless he is.
118. Brags about how good he is.
119. Says the same thing over and over again.
120. Complains about people and things in general.
121. Talks about big plans he has for the future.
122. Says or acts as if people are after him.
123. Says that something terrible is going to happen.
124. Believes in strange things.
125. Talks about suicide.
126. Talks about strange sexual ideas.
127. Gives advice without being asked.

TABLE 2

Items comprising Level of Performance of Socially-expected Activities (KAS) Form R2. The scale format for the items in Form R2 is:

1	2	3
is not doing	is doing some	is doing regularly

1. Helps with household chores.
2. Visits his friends.
3. Visits his relatives.
4. Entertains friends at home.
5. Dresses and takes care of himself.
6. Helps with the family budgeting.
7. Remembers to do important things on time.
8. Gets along with family members.
9. Goes to parties and other social activities.
10. Gets along with neighbors.
11. Helps with family shopping.
12. Helps in the care and training of children.
13. Goes to church.
14. Takes up hobbies.
15. Works.
16. Supports the family.

TABLE 3

Level of Expectations for Performance of Social Activities (Form R3). The item scale format for Form R3 is:

1	2	3
did not expect him to be doing	expected him to be doing some	expected he'd be doing regularly

1. Helps with household chores.
2. Visits his friends.
3. Visits his relatives.
4. Entertains friends at home.
5. Dresses and takes care of himself.
6. Helps with the family budgeting.
7. Remebers to do important things on time.
8, Gets along with family members.
9. Goes to parties and other social activities.
10. Gets along with neighbors.
11. Helps with family shopping.
12. Helps in the care and training children.
13. Goes to church.
14. Takes up hobbies.
15. Works.
16. Supports the family.

TABLE 4

Items comprising Level of Free-time Activities (KAS) Form RS4. The scale format for the items in Form RS4 is:

1	2	3
frequently	sometimes	practically never

1. Work in and around the house.
2. Work in the garden or yard.
3. Work on some hobby.
4. Listen to the radio.
5. Watch television.
6. Write letters.
7. Go to the movies.
8. Attend lectures, theatre.
9. Attend club, lodge, other meetings.
10. Shop.
11. Take part in community or church work.
12. Bowl or other sports.
13. Play cards or other table games.
14. Take rides.
15. Visit friends.
16. Entertain friends.
17. Sew, crochet or knit.
18. Read.
19. Go to the library.
20. Just sit and think.
21. Take courses at home.
22. Go to school.
23. Other (what?).

TABLE 5

Level of satisfaction with Free-time Activities (Form R5). The item scale format for Form R5 is:

1	2	3
satisfied with what he does here	would like to see him do more of this	would like to see him do less

1. Work in and around the house.
2. Work in the garden or yard.
3. Work on some hobby.
4. Listen to the radio.
5. Watch television.
6. Write letters.
7. Go to the movies.
8. Attend lectures, theatre.
9. Attend club, lodge, other meetings.
10. Shop.
11. Take part in community or church work.
12. Bowl or other sports.
13. Play cards or other table games.
14. Take rides.
15. Visit friends.
16. Entertain friends.
17. Sew, crochet or knit.
18. Read.
19. Go to the library.
20. Just sit and think.
21. Take courses at home.
22. Go to school.
23. Other (what?).

APPENDIX D

LETTER TO PARTICIPANTS

March, 1973

Dear Participant,

As you have discussed with your psychiatrist, this is to give you some basic information about the encounter group you will attend. In specifying the nature of the group itself, I can only say at this time that it is designed as a therapeutic experience for you, the specific course of which will evolve from the particular needs of the participants.

The group is a live-in experience. The dates are: March 21, at 10 am through to March 25, at approximately noon. The place is Holy Redeemer College, Edmonton. The cost is $32. Alberta Health Care will pay for the therapists' services. You will require toiletries and clothing for the five days; food, lodging, towels, etc, will be provided.

This experience has been designed as a research project to assess the effectiveness of group treatment. A condition of your participation is that you answer some questionnaires and be interviewed and rated by a family member or close friend whom you feel knows you very well and has a good deal of contact with you. Your responses will be entirely confidential and results of the research will be reported for the group as a whole. There will be no individual identification at any point. The time for collection of data which, hopefully, causes you the least inconvenience and interferes least with the group, has been set for March 20 at 7.30 pm in Dr Julius Guild's office, room 1243, Royal Alexandra Hospital, where all group participants will meet for approximately two hours. Please bring the family member, or friend, with you at this time. You will be asked to complete questionnaires, be interviewed, and your close friend or family member will complete a form to help describe you. At this time you can perhaps also arrange with other participants for transportation to Holy Redeemer College for the next morning.

The second set of data will be collected from you at the completion of your group experience at the college, on March 25 around noon. Your family member or friend is not required to attend or provide data at this time although he will be asked to return to the Royal Alexandra Hospital (room 1243) on the following Saturday, March 31 at 10.30 am, to complete the rating.

A final, follow-up collection of information will be done three months later, on Wednesday, June 20 at 7.30 pm, in room 1243 at the Royal Alexandra Hospital. Please bring your friend or family member with you on this date. Questionnaires, interviews and ratings will be finalized at this time.

The dates again, are -

March 20th, 7.30pm - data collection at the Royal Alexandra Hospital (bring family member or friend),
March 21st, 10am - group starts at Holy Redeemer College (come alone),
March 25th, noon - group ends at Holy Redeemer College,
March 25th, noon - data collection at Holy Redeemer College (no friend or family member),
March 31st, 10.30 am - data collection at Royal Alexandra Hospital (friend or family member only),
June 20th, 7.30pm - data collection at Royal Alexandra Hospital (bring friend or family member).

I trust I have not made this all appear so complicated as to cause you anxiety and doubts about your participation. It is a fairly routine and simple procedure and will, hopefully, seem only a slight nuisance in the face of the rewards from other group sessions.

If you have further questions please ask your psychiatrist or call me at his request. I am trusting this will be a most rewarding experience for you and thank you for aiding me in the research.

Yours truly,

Carol Ganam (Researcher)

APPENDIX E

BRIEF PSYCHIATRIC RATING SCALE

BRIEF PSYCHIATRIC RATING SCALE
OVERALL AND GORHAM

Directions: Draw a circle around the term under each symptom which best describes the patient's condition.

1. Somatic Concern - Degree of concern over present bodily health. Rate the degree to which physical health is perceived as a problem by the patient, whether complaints have realistic basis or not.

Not present Very mild Mild Moderate Mod. severe Severe Extremely severe

2. Anxiety - worry, fear, or over-concern for present or future. Rate solely on the basis of verbal report of patient's own subjective experiences. Do not infer anxiety from physical signs or from neurotic defense mechanisms.

Not present Very mild Mild Moderate Mod. severe Severe Extremely severe

3. Emotional Withdrawal - Deficiency in relating to the interviewer and the interview situation. Rate only degree to which patient gives the impression of failing to be in emotional contact with other people in the interview situation.

Not present Very mild Mild Moderate Mod. severe Severe Extremely severe

4. Conceptual Disorganization - Degree to which the thought processes are confused, disconnected or disorganized. Rate on the basis of integration of the verbal products of the patient; do not rate on the basis of the patient's subjective impression of his own level of functions.

Not present Very mild Mild Moderate Mod. severe Severe Extremely severe

5. Guilt Feelings - Over-concern or remorse for past behavior. Rate on the basis of the patient's subjective experiences of guilt as evidence of verbal report with appropriate affect; do not infer guilt feelings from depression, anxiety or neurotic defenses.

Not present Very mild Mild Moderate Mod. severe Severe Extremely severe

6. Tension - Physical and motor manifestations of tension, "Nervousness", and heightened activation level. Tension should he rated solely on the basis of physical signs and

motor behavior and not on the basis of subjective experiences of tension reported by the patient.

Not present Very mild Mild Moderate Mod. severe Severe Extremely severe

7. Mannerisms and Posturing - Unusual and unnatural motor behavior, the type of motor behavior which causes certain mental patients to stand out in a crowd of normal people. Rate only abnormality of movements; do not rate simple heightened motor activity here.

Not present Very mild Mild Moderate Mod. severe Severe Extremely severe

8. Grandiosity - Exaggerated self-opinion conviction of unusual ability or powers. Rate only on the basis of patient's statements about himself or self-in-relation-to-others, not on the basis of his demeanor in the interview situation.

Not present Very mild Mild Moderate Mod. severe Severe Extremely severe

9. Depressive Mood - Despondency in mood, sadness. Rate only degree of despondency; do not rate on the basis of inferences concerning depression based upon general retardation and somatic complaints.

Not present Very mild Mild Moderate Mod. severe Severe Extremely severe

10. Hostility - Animosity, contempt, belligerence, disdain for other people outside the interview situation. Rate solely on the basis of the verbal report of feelings and actions of the patient toward others; do not inter hostility from neurotic defenses, anxiety nor somatic complaints. (Rate attitude toward interviewer under "co-operativeness".)

Not present Very mild Mild Moderate Mod.severe Severe Extremely severe

11. Suspiciousness - Belief (delusional or otherwise) that others have now, or have had in the past, malicious or discriminatory intent toward the patient. On the basis of verbal report, rate only those suspicions which are currently held whether they concern past or present circumstances.

12. Hallucinatory Behavior - Perceptions without normal external stimulus correspondence. Rate only those experiences which are reported to have occurred within the last week and which are described as distinctly different from the thought and imagery processes of normal people.

13. Motor Retardation - Reduction in energy level evidenced in slowed movements and speech, reduced body tone, decreased number of movements. Rate on the basis of observed behavior of the patient only; do not rate on basis of patient's subjective impression of own energy level.

14. Uncooperativeness - Evidence of resistance, unfriendliness, resentment, and lack of readiness to cooperate with the interviewer. Rate on the basis of the patient's attitude and responses to the interviewer and the interview situation; do not rate on basis of reported resentment or uncooperativeness outside the interview situation.

15. Unusual Thought Content - Unusual, odd, strange, or bizarre thought content. Rate here the degree of unusualness, not the degree of disorganization of thought processes.

16. Blunted affect - Reduced emotional tone, apparent lack of normal feeling or involvement.